Children's Cancer Connection New Family Form

Children's Cancer Connection (CCC) is here to help you through your journey. Our resources, services and programs are free and available when you feel the time is right to participate. **In order to become an enrolled CCC family, you must complete and return this paper form to your healthcare team or complete the form online at childrenscancerconnection.org.**

Oncology Patient

Child's Name:____ Gender:__________

Ethnicity: □ Caucasian □ Hispanic/Latino □ Black/African American □ Asian □ Indigenous American □ Native Hawaiian or Pacific Islander

Diagnosis:____ Diagnosis Date:______________

Treatment Facility: ☐ Blank Children's Hospital ☐ University of Iowa ☐ Other:__________________

Child's Birth Date:____________________ Graduation Month/Year:____________________

Child lives with: ☐ Both parents ☐ Mom only ☐ Dad only ☐ Other (specify):____________________

Siblings

If your family has more than three siblings, please email programs@childrenscancerconnection.org.

Sibling's Full Name:____ Gender:__________

Ethnicity: □ Caucasian □ Hispanic/Latino □ Black/African American □ Asian □ Indigenous American □ Native Hawaiian or Pacific Islander

Sibling's Birth Date:____________________ Graduation Month/Year:____________________

Sibling's Full Name:____ Gender:__________

Ethnicity: □ Caucasian □ Hispanic/Latino □ Black/African American □ Asian □ Indigenous American □ Native Hawaiian or Pacific Islander

Sibling's Birth Date:____________________ Graduation Month/Year:____________________

Sibling's Full Name:____ Gender:__________

Ethnicity: □ Caucasian □ Hispanic/Latino □ Black/African American □ Asian □ Indigenous American □ Native Hawaiian or Pacific Islander

Sibling's Birth Date:____________________ Graduation Month/Year:____________________

Parents/Guardians

Parent 1 Full Name:____ Prefix: ☐ Mr. ☐ Mrs. ☐Ms.

Ethnicity: □ Caucasian □ Hispanic/Latino □ Black/African American □ Asian □ Indigenous American □ Native Hawaiian or Pacific Islander

Address:__________________________________ City, State, Zip:______________________

County: ____________________ Phone: (   ) ______________ Email: ____________________

Employer:____

Employer information is optional, but it is helpful as CCC uses it for corporate donation purposes.

Parent 2 Full Name:____ Prefix: ☐ Mr. ☐ Mrs. ☐Ms.

Ethnicity: □ Caucasian □ Hispanic/Latino □ Black/African American □ Asian □ Indigenous American □ Native Hawaiian or Pacific Islander

Address:__________________________________ City, State, Zip:______________________

County: ____________________ Phone: (   ) ______________ Email: ____________________

Employer:____

Employer information is optional, but it is helpful as CCC uses it for corporate donation purposes.

By signing below, I acknowledge that the individually identifiable information that I am providing to Children's Cancer Connection does not constitute protected health information as that term is defined by the Health Insurance Portability and Accountability Act (HIPAA). I understand that while Children's Cancer Connection will use commercially reasonable efforts to protect such individually identifiable information, such information is not protected by HIPAA when it is used or disclosed by Children's Cancer Connection.

Signature:____ Date:______________