

# 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](http://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](mailto: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: \_\_\_\_\_

