

Children's Cancer Connection New Family Form

Children's Cancer Connection is here to help you through your journey. Our resources, services and programs are free and always available when you feel the time is right to participate.



Sign up at childrenscancerconnection.org/new-family.html or scan the QR code. If preferred, you may complete this form and give it to a member of your healthcare team.

Important: in order to become an enrolled CCC family, you must complete and return this form

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 support@childrenscancerconenction.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.

Signature: _____ Date: _____

I authorize my healthcare team to return this form to Children's Cancer Connection so that I may receive more information.

