

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 support@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: _____

