HIS KIDS CANCER SUPPORT

Family Information Form

To sign up for our programs, please return this form to your social worker or send it to the HIS KIDS office at:
Po Box 412
Highland, IL 62249
or
kidsinfo@hiskidsinc.org

MEDICAL TREATMENT FACILITY: _____

Child #1
Patient's Full Name: _____

☐ M ☐ F Date of Birth_____ Age:_____

Address: _____

City/St/Zip_____

Home Phone _____

Email _____ **(please provide)**

Diagnosis: _____

Date of Diagnosis: _____

Physician: _____

Treatment Plan: _____

Hosp. Social Worker's name:

_____

FAMILY INFORMATION: Additional Children

Sibling Full Name	Sex	Age	Date of Birth	Live in same household
Child #2)	M F		___/___/___	Yes No
Child #3)	M F		___/___/___	Yes No
Child #4)	M F		___/___/___	Yes No
Child #5)	M F		___/___/___	Yes No
Child #6)	M F		___/___/___	Yes No
Child #7)	M F		___/___/___	Yes No

Mother's Name: _____
Employer _____
Work Phone (____) _____
Cell Phone (____) _____
Email_____

Father's Name _____
Employer _____
Work Phone (____) _____
Cell Phone (____) _____
Email_____

Total number in household: _____

Does ill child live with both parents? Y or N If not, who has legal custody?_____

_____

Additional Information:_____

_____

THE INFORMATION GIVEN IS FOR HIS KIDS PROGRAMS & SERVICES AND WILL NOT BE RELEASED TO ANY OTHER ENTITY

Signature of Legal Guardian/Parent

_____

Date

_____

return via fax: 618-654-4499 or email: kidsinfo@hiskidsinc.org