Junior Foundation Charities

LANGUAGE PREFERANCE:

☐ **ESPAÑOL** ☐ **ENGLISH**

EMPOWERING KIDS WITH CANCER

FAMILY APPLICATION

(Please type or print in black ink)

PATIENT FULL NAME: _____
(Legal Name) Last First Middle

PATIENT DATE OF BIRTH: _____ CURRENT AGE: _____ GENDER: ❑ Male ❑ Female

PATIENT HOME ADDRESS:

_____
Street

_____
Apartment Number

_____
City

_____
State Zipcode

PATIENT DIAGNOSIS:

Type of Cancer: _____

Treatment Facility/Hospital:
❑ CHOC ❑ CHLA ❑ LLUCH ❑ Miller's Long Beach ❑ City of Hope

❑ Kaiser _____ ❑Other: _____
PLEASE STATE THE CITY KAISER IS LOCATED IN PLEASE STATE HOSPITAL OF TREATMENT

Age at Diagnosis: _____

HOME PHONE NUMBER: _____
Include Area Code

EMAIL ADDRESS: _____
This is Our MAIN FORM OF CONTACT - Please list an Email Address for Contact by Our Organization

PARENT/GUARDIAN INFORMATION:

MOTHER'S FULL NAME: _____
MOTHER'S EMAIL: _____
MOTHER'S CELL PHONE #: _____

FATHER'S FULL NAME: _____
FATHER'S EMAIL: _____
FATHER'S CELL PHONE #: _____

PRIMARY CONTACT: ❑ Mother ❑ Father ❑ Other: _____

SIBLING INFORMATION:

FULL NAME: _____ BIRTHDATE: _____ ❑ Male ❑ Female
FULL NAME: _____ BIRTHDATE: _____ ❑ Male ❑ Female
FULL NAME: _____ BIRTHDATE: _____ ❑ Male ❑ Female
FULL NAME: _____ BIRTHDATE: _____ ❑ Male ❑ Female
FULL NAME: _____ BIRTHDATE: _____ ❑ Male ❑ Female
FULL NAME: _____ BIRTHDATE: _____ ❑ Male ❑ Female

PLEASE ADD ME TO THE JUNIOR FOUNDATION CHARITIES FAMILY MAILING LIST
❑ Yes ❑ No

YOU HAVE AUTHORIZATION TO USE PICTURES OF MY CHILD
❑ Yes ❑ No

I AM AVAILABLE TO RECEIVE TICKETS FOR SPORTING & OTHER EVENTS WITH SHORT NOTICES ❑ Yes ❑ No

SIGNATURE: _____ DATE: _____

ETHNICITY & RACE:
(Optional— for statistical purposes)

Select One
❑ Hispanic or Latino ❑ Not-Hispanic or Latino

Select all that Apply
❑ American Indian or Alaska Native
❑ Asian
❑ Black or African American
❑ Native Hawaiian or Other Pacific Islander
❑ White
❑ Other

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