Kids Alive!

Support for Children of Parents with Cancer

FAMILY INFORMATION

Please fill out one form per family participating in the group.

	Mother	Father
Name:		
Address:		
Telephone:		

Names and ages of children:

Name	Age	Participating in Kids Alive? (Yes/No)

Address to which all communications regarding Kids Alive should be sent:

_____ E-Mail Address_____

_____

Name of parent diagnosed with cancer:_____

Type of cancer: _____

Stage of cancer: _____

Treatment status: _____

Name of Oncologist: _____

How did you learn about Kids Alive? _____

***PLEASE NOTE - There are 4 pages to this application.*

****

Office use only:

Date application received_____ Parents interviewed scheduled: _____

PARENT'S QUESTIONNAIRE
KIDS ALIVE: Support for Children of Parents with Cancer

Parent's Name: _____ Child's Name: _____

Date of Birth: _____ Age: _____

Please fill out <u>one form for each child</u> who will be participating in the support group.

Check those behaviors that apply:

Behaviors	Current Behaviors	Began After Cancer Diagnosis	Began Before Cancer Diagnosis
Clinging	☐	☐	☐
Refusal to part with a parent	☐	☐	☐
Verbal and/or physical aggression	☐	☐	☐
Baby talk; infantile behavior	☐	☐	☐
Withdrawing, disappearing in room	☐	☐	☐
Silence, refusal to talk, sulking	☐	☐	☐
Refusal to talk about the cancer	☐	☐	☐
Over-responsible	☐	☐	☐
Complaining, particularly about illness or getting hurt	☐	☐	☐
Accident proneness	☐	☐	☐
Overly adult talk, mannerisms	☐	☐	☐
Significant changes in school or social behaviors	☐	☐	☐
Attention seeking	☐	☐	☐
Eating problems	☐	☐	☐
Sleep disturbances	☐	☐	☐
Poor school performance	☐	☐	☐
Sexual acting out	☐	☐	☐

Other (write in) _____

_____

_____

Does this child have any medical problems, including medication, allergies, etc.?

_____

_____

_____

Restrictions in activity, if any:

_____

_____

_____

Who should be contacted in case of emergency?

Name:_____ Address:_____ Phone:_____

_____

Family doctor or pediatrician:

Name: _____ Address:_____ Phone: _____

_____

Significant academic or school problems:

_____

_____

_____

PORTER ADVENTIST HOSPITAL

PARENTAL CONSENT, WAIVER AND RELEASE

Please fill out <u>one form per child</u> participating in the group.

1. I, the undersigned, desire to have my child to participate in Porter Adventist Hospital's Support Group For Children Of Parents With Cancer ("Support Group"). I understand that my child's participation in the Support Group will involve various activities, including, but not limited to, discussion groups, outings and possible overnight trips. I also understand that some of these activities may be photographed or videotaped.

2. I hereby consent to my child's participation in the activities in the Support Group, including, but not limited to, discussion groups, outings and possible overnight trips.

3. I hereby consent to the taking of photographs or videotapes of my child participating in the Support Group.

4. I understand that while participating in the Support Group my child may make statements to counselors and other Support Group staff which are confidential. I understand and agree that this information will not be provided or released to me or third parties except where necessary to protect the health and safety of the child.

5. I hereby agree to hold Porter Adventist Hospital, it's officers, employees and agents free and harmless from any claims, actions, cost or expenses arising in connection with my child's participation in the Support Group. Furthermore, I consent to the release or use of photographs and videotapes of my child while participating in the Support Group. I agree that such photographs and videotapes shall be the exclusive property of Porter Adventist Hospital and I, or my child, shall have no right to the photographs or videotapes or to any compensation for publication or other use of such photographs or videotapes by Porter Adventist Hospital.

I HAVE READ AND UNDERSTAND EACH PROVISION OF THIS PARENTAL CONSENT, WAIVER AND RELEASE REGARDING MY CHILD'S PARTICIPATION IN THE SUPPORT GROUP.

Dated this _____ day of _____, 20___.

Child's Information:

_____	_____	_____	_____
Last Name	First	Middle Initial	Birth Date

_____	_____	_____	_____	_____
Address	City	County	State	Zip

In case of emergency contact: _____ at (telephone) _____

Signature of parent or guardian: _____ Date:_____

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