



Childhood Cancer Programs

Families Can ♥ Survive

Weekend

December 2rd to December 4th 2011

REGISTRATION FORM

Child's Name: _____ / _____
Last Name First Name

Birth date: ____/____/____ Age: _____ Sex: M F

Date of Diagnosis: ____/____/____ Type of Cancer: _____

Parent(s) or Guardian(s): _____
Please Print Names

Resident Island/Territory:

- Oahu
- Maui
- Molokai
- Lanai
- Big Island Hawaii
- Kauai
- Guam

Address: _____ City & Zip: _____

Home Phone: _____ Work: _____ / _____ Cell: _____ / _____
Mother Father Mother Father

Email Address: _____

Doctor's Name: _____ Phone: _____ Hospital: _____

Insurance: _____ Policy #: _____

Emergency Contact: _____ Relationship: _____ Phone: _____

Special Accommodations: _____ Specific Dietary Needs: _____

NOTE: List immediate family members ONLY, i.e. Mother & Father or Guardians, Siblings (18 and under only); list t-shirt sizes

Names of Family Members	Relationship (patient)	Age	Child				Adult					
			XS	S	M	L	S	M	L	XL	2X	3X
_____	_____	_____										
_____	_____	_____										
_____	_____	_____										
_____	_____	_____										
_____	_____	_____										
_____	_____	_____										

Parent/Guardian Signature: _____ Date: _____

Childhood Cancer Programs Director
American Cancer Society Hawai'i Pacific, Inc.