American Childhood Cancer Organization Inland Northwest (ACCOIN)

Affiliate of American Childhood Cancer Organization (ACCO)
P.O. Box 8031, Spokane, WA 99203 (509) 474-2759
www.acco.org/inlandnw

NEW FAMILY MEMBERSHIP AND RELEASE FORM

Patient Information Today's Date ________________

Child's Name ____ M F Date of Birth ____________________________

Diagnosis ____Date of Diagnosis ________________________

Oncologist Name ____ Oncologist Phone _______________________

*If treated at a facility other than Sacred Heart Children's Hospital, a separate signed release for physician's confirmation is required.

Interests and Hobbies ____

Favorite Toys/Team/Activities/SuperHero____

Family Information

Father's Name (or Guardian) ____

Address ____

City ______________________________________ State _____ Zip __________ Home Phone ________________________

Cell Phone __________________ Other __________________Email Address ______________________________________

Mother's Name (or Guardian) ____

Address (if different) ____

City ______________________________________ State _____ Zip __________ Home Phone ________________________

Cell Phone __________________ Other _________________ Email Address ______________________________________

Siblings

(Specify if last name is different, continue on back if necessary)

Name ____Date of Birth ______________ M F

Name ____Date of Birth ______________ M F

Name ____Date of Birth ______________ M F

Any other information to help us serve you better: ____

____

____

Information Release and Authorizations

(Check all applicable authorizations below)

Yes	No	
☐	☐	I authorize use of my family's names and my child's diagnosis in ACCOIN/ACCO's print and electronic publications.
☐	☐	I give consent for photographs of myself, my child, and /or family to be used in print, broadcast and electronic media for the purpose of promoting childhood cancer awareness and the mission of ACCOIN/ACCO. Release expires two years from date of signature.

We communicate with families about services/events through e-newsletter, email, and mail. To Opt OUT Initial Here________

I hereby authorize my child's treating oncologist and/or medical team to confirm with ACCOIN my child's diagnosis, current condition and ways that ACCOIN/ACCO can assist my child and family. This does not authorize the release of medical records.

Signature of Parent/Guardian____

Printed Name and relationship of signer____

Signature of Patient if over 18 years old____

ACCO compiles demographic information in a national data base for the sole purpose of gathering national statistics about childhood cancer. Information is never sold.

Renewable three year membership