

Application/Referral Form: Haven of Hope for Kids

*Please complete and return this application to your hospital social worker

Patient Information

Patient's last name _____ Patient's first name _____

Gender: male female Date of Birth _____ Nickname _____

Address _____

City _____ State _____ Zip _____

Home phone _____ Email _____

Diagnosis _____ Date of Diagnosis _____

Treatment Center/Outpatient clinic _____

Address _____

City _____ State _____ Zip _____

Office phone _____ Emergency phone _____

Office fax _____

Physician Name (s) _____

Social Worker _____ Phone _____

Family Information

Primary Language: _____

Name of parent(s) or guardian(s) that the patient lives with _____

Parent/Guardian #1 _____

Relationship _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Parent/Guardian #2 _____

Relationship _____

Address _____

City _____ State _____ Zip _____

Home Phone _____ Work Phone _____

Cell Phone _____ Email _____

Emergency Contact (someone who is not attending retreat)

Name _____ Relationship _____

Home Phone _____ Cell Phone _____

What kind of activities do you hope to participate in while at Haven of Hope for Kids?

Would you be interested in learning more about spiritual/religious support that is available during your stay?

List all immediate family members (mother, father, siblings) who will also attend the retreat.

Parent/Guardian Legal Name	Relationship to Patient	DOB/Age at time of camp
----------------------------	-------------------------	-------------------------

1. _____	_____	_____
----------	-------	-------

2. _____	_____	_____
----------	-------	-------

Siblings Name

1. _____	_____	_____
----------	-------	-------

2. _____	_____	_____
----------	-------	-------

3. _____	_____	_____
----------	-------	-------

4. _____	_____	_____
----------	-------	-------

5. _____	_____	_____
----------	-------	-------

6. _____	_____	_____
----------	-------	-------

Please give details below if any of above family members is under the care of a physician or mental health professional for a medical or emotional problem.

CHILD'S MEDICAL HISTORY

Diagnosis:

Medications and dosages:

Has your child had chicken pox?

Has your child had the vaccine? If so, please give the date:

Does your child have a positive titer?

Dietary restrictions or food allergies:

Drug allergies:

Physical limitations:

Does child use crutches, wheelchair, etc?

Special needs:

Insurance information (please attach copy of insurance card):

Any additional information you think is important to add:

Do we have permission to use photographs of your child or your family in promoting our program?

Physician's Approval

_____ (name of child) is medically cleared to attend the Haven of Hope for Kids program. Any limitations or restrictions are noted on this form.

Physician's Signature: _____

Physician's Name (printed): _____

Date: _____

Phone: _____

Phone (in case of emergency): _____