We Care Child Enrollment Form

Child's Information

Full Name:

_____

Date of Birth: _____ Age:_____ Gender: _____
Ethnicity_____

Address:_____

City:_____ State:_____
Zip:_____

Insurance: YES NO Provider
Name:_____

School Attended:_____
Grade:_____

Guardian Information

Guardians Full
Name:_____

Relationship to
child:_____

Phone:_____
Email:_____

Address (if different from
child):_____

Emergency Contact

Name:_____
Address:_____

Relationship to Child:_____
Phone:_____

Household Information

List all names and age of residents in the home and relationship to child

_____

_____

_____

_____

Medical Information

Primary Physician:_____Phone:_____

Hematologist/Oncologist:_____

Diagnosis:_____Diagnosis Date:_____

Hospital:_____

Guardian Consent

I,_____, as the legal guardian

Of _____, give my consent for my child to be enrolled in the We Care program.

I also authorize We Care to collect, store and use my child's information, including health, demographic, and program participation data, for the purpose of applying for grants and securing funding to support the We Care Foundation. I understand that any information used for grant purposes will be kept confidential and shared only in ways that protect the identity of my child.

Guardian Signature:_____**Date**:_____

Staff Signature:_____**Date**:_____

Notes:_____

_____

_____

_____

We Care Foundation Treatment Verification Form

Patient Information

Name:_____

Date of Birth:_____Phone:_____

Hematologist/Oncologist Information

Name:_____

Name of
Hospital:_____

Phone:_____

Fax:_____

Address:_____

Medical Information

Name of Diagnosis:_____ Diagnosis Date:_____

Start date of Treatment:_____Completion Date:_____

Treatment type: ☐ Oral Chemo ☐ IV Chemo ☐ Radiation ☐ Other

Frequency: ☐ Monthly ☐ Bi-Weekly ☐ Weekly ☐ Daily ☐ Other

Doctor/Staff Signature:_____
Date:_____

We Care Staff
Signature:_____**Date**:_____

The Treatment Verification Form for We Care is used to confirm a child's medical diagnosis and treatment plan, and must be signed by the treating doctor to ensure eligibility for support services and programs.

ED: Tasha Schluterman **Phone**: 479-462-5070 **Email**:Tasha@wecarefoundationfs.org

We Care Foundation
Media Release Form
Permission for Use of Likeness, Photographs, Videos, and Statements

Participant Name: _____
Parent/Guardian Name (if under 18): _____
Phone Number: _____
Email Address: _____

Consent for Media Use

I hereby grant permission to **We Care Foundation** and its representatives to take and use photographs, video recordings, and/or digital images of me (or my child, if under 18) for the purposes of promoting the mission of We Care Foundation. This includes, but is not limited to:

- Use on the We Care Foundation website
- Use on We Care's social media platforms (e.g., Facebook, Instagram, Twitter, TikTok)
- Inclusion in promotional or fundraising materials
- Use in press releases or public reports

I understand that:

- No royalty, fee, or compensation shall become payable to me by reason of such use.
- These images and recordings may be used in composite or modified forms.
- I may revoke this authorization at any time by submitting a written request to We Care Foundation, but it will not affect prior use.

Please select one:
☐ I give permission for **photo, video, and name** to be used.
☐ I give permission for **photo and video only** (no name).
☐ I do **not** give permission for any media use.

Signature

Signature of Participant (or Parent/Guardian if under 18):
Signature: _____
Date: _____

Printed Name: _____