

KIDS CAN COPE
Registration Form

Session (Date):	Location:
How family heard about KCC Program?	
Hosp. Staff _____ Brochure/Poster _____ CCS _____	
Family Friend _____ Other _____	

Parents			
Person with Illness		Occupation:	Age:
Treatment Location			
Home Address			
Postal Code		Phone Number	
Diagnosis		Current Condition	

				Any Known Allergies
Names(s) of Children	Age	Grade	Birth Date	

Transportation Needs		
Name of Child	Pick Up (Where & Time)	Return

Other: (egg. Other Counselors/agencies involved, any medications/conditions, etc.)

Facilitators:	Group:
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