



SCHOOL AWARENESS SERVICES

REGISTRATION FORM

School: _____

Address: _____

Telephone: _____ Region: _____

Requested by:

The patient's parents	<input type="checkbox"/>
The patient	<input type="checkbox"/>
A teacher	<input type="checkbox"/>
The school's director	<input type="checkbox"/>

Information about the request:

1. School:

Director's first name and last name:	_____
Telephone:	_____
Email:	_____
Contact-person for the activity:	_____
Telephone:	_____
Email:	_____

2. Patient:

Patient's first name and last name:	_____	
Age:	_____	
School grade:	_____	
Diagnosis:	_____	
Is the patient a student in your school?	YES	NO
Is the patient under treatment?	YES	NO

3. Parents:

Mother's name:	_____
Address:	_____
Telephone:	_____
Email:	_____
Father's name:	_____
Address:	_____
Telephone:	_____
Email:	_____

4. Siblings:

Child's first name and last name:	_____
Age:	_____
School grade:	_____
Present school attending:	_____
Child's first name and last name:	_____
Age:	_____
School grade:	_____
Present school attending:	_____
Child's first name and last name:	_____
Age:	_____
School grade:	_____
Present school attending:	_____

What kind of services would you like to receive?:

School Awareness in the child's class	<input type="checkbox"/>
School Awareness in the siblings' class	<input type="checkbox"/>
General School Awareness	<input type="checkbox"/>
"My friend needs my help" Money Box Campaign	<input type="checkbox"/>
Shaved Head Challenge	<input type="checkbox"/>
Read-o-thon	<input type="checkbox"/>

Information about the school:

	Number of classes to be visited	Number of students per class
Kinder garden		
1st grade		
2nd grade		
3rd grade		
4th grade		
5th grade		
6th grade		
Special class		
Total		

Dates and hours for the visit:

Dates	A.M.	P.M.

Dates for the visit:

Dates	Hours	Number of classes visited

Volunteers:

Names	Dates

Particular or complementary information:

Person in charge of following up the project and welcoming the volunteer:

Telephone :

Signature:

Date: _____