DCH Ambassador Family Program

Application

Patient First and Last Name _____

Nickname _____

Age _____ DOB _____ ☐ Male ☐ Female Grade _____

Diagnosis _____

Date of diagnosis _____

Are you currently being treated? _____ Allergies _____

What departments/doctors do you visit/have visited? _____

_____

_____

Address _____ City _____ ST _____ ZIP _____

Parent/Legal Guardian Name _____ Relationship to patient _____

Email address _____ Cell phone _____

Parent/Legal Guardian Name _____ Relationship to patient _____

Email address _____ Cell phone _____

Do you prefer phone calls or texts? To which parent? What is the best time to contact you?

_____

Names and ages of patient's siblings _____

_____

_____

Patient and family members' shirt sizes _____

_____

_____

_____

What is the patient's favorite thing about Driscoll?_____

_____

_____

_____

Favorite Driscoll staff member?_____

Favorite school subject? _____

Favorite food?_____

Favorite sports team? _____

Favorite movie? _____

Favorite color?_____

Hobbies or favorite things to do?_____

What else should we know about the patient? _____

_____

_____

For questions or to return completed form:

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