

## Patient Application

OFFICE USE ONLY		
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Holding Hope is a 501(c)3 nonprofit organization that supports families of children with life-threatening illnesses being treated at Penn State Hershey Children's Hospital. For more information, please call **(717) 982-8126** or visit our website **[www.holdinghope.org](http://www.holdinghope.org)**.

### Personal Information (To be completed by parent/guardian) PLEASE PRINT CLEARLY

Child's Name:

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(First) (Middle) (Last)

Date of Birth:

(month/day/year)

Sex:

Age:

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Home Address:

(number/street address)

(County)

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City:

State:

Zip Code:

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Home Phone:

Cell Phone:

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Work Phone Father:

Mother:

---

Email Address Father:

Mother:

---

Mother's Name:

First

Last

---

Employer Name & Address:

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Father's Name:

First

Last

---

Employer Name & Address:

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Legal Guardians (if other than parents):

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PLEASE PRINT CLEARLY

Child's special interests and hobbies:

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Please list the names and ages of all other children living at home:

Name

Birth date

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Name

Birth date

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Name

Birth date

---

Name

Birth date

---

Please list the name, age, and relationship of any other person residing with the child:

Name

Birth date

Relationship

---

Name

Birth date

Relationship

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### Medical Information

Name of Physician:

(First)

(Last)

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Phone Number:

Fax Number:

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Name of Social Worker:

(First)

(Last)

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Phone Number:

Fax Number:

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Diagnosis:

Date of Diagnosis:

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Brief Description of Treatment:

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*This application is considered current for one year after date signed by Parent/Guardian.*

*I understand and recognize that participation in any Holding Hope Program is contingent upon approval by Holding Hope as well as compliance with all conditions, qualifications and restrictions designated by Holding Hope.*

*I authorize Penn State Hershey Hospital to release information needed to confirm my application to Holding Hope.*

**Parent/Guardian**

Date

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**Parent/Guardian**

Date

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