A Program of
Nevada Childhood
Cancer Foundation

CAREGIVER REGISTRATION

A caregiver is defined as a person who helps an individual diagnosed with cancer (within FIVE years of diagnosis) with daily living activities including assisting with medication, bathing, dressing, meal preparation and doctor's appointments.

PLEASE PRINT CLEARLY

CAREGIVER'S NAME (Last, First, & Middle Initial):_____
Widowed ____**Yes** ____**No** **Date of Birth:**_____

Cell Phone: _____**Home Phone:** _____

OK to leave a message? Yes ___ No ___ **Email:** _____

PATIENT'S NAME: (Last, First & Middle Initial):_____

PATIENT'S PHONE: (If applicable):_____

PATIENT'S ONCOLOGIST'S NAME:_____

I GIVE THE CARING PLACE PERMISSION TO CONFIRM ONCOLOGY/PATIENT INFORMATION: Yes___ No___

Caregiver's Address: (Include apartment number if any)

_____

_____
City State Zip

Emergency Contact_____ **Phone:** _____

Relationship:_____

If Professional Caregiver:

Home Healthcare Agency: _____ **Phone**:_____

I understand that as a caregiver, I will be permitted to participate in group activities with my participant. Individual sessions such as massage, reflexology and Reiki will be available on a limited basis as priority is given to cancer survivors and those currently in treatment.

_____

All answers and statements on this registration and any other materials I have submitted to apply as a participant in The Caring Place programs and services are true and complete to the best of my knowledge. I understand that The Caring Place may verify this information. Untruthful or misleading answers are cause for rejection of this registration.

Signature:_____Date:_____

If under 18 years of age, legal guardian must sign. Legal Guardian Signature: _____

Form Revised: 3/5/20

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LIABILITY WAIVER

The Caring Place is a program of Nevada Childhood Cancer Foundation, a 501(c)3 non-profit organization. Participation in programs, classes and services provided by or sanctioned by Nevada Childhood Cancer Foundation includes, but is not limited to participation in group programs such as support groups, yoga, exercise and movement classes, art classes, meditation and guided imagery, as well as individual modalities such as Massage Therapy, Reiki, Craniosacral Therapy and Reflexology.

I understand that participation in programs, classes or services on or off site is completely voluntary. I understand that programs, classes, and services provided by Nevada Childhood Cancer Foundation are not in place of medical treatment and that volunteers who provide programs and sessions are not medically trained, nor do they dispense medical advice. By signing below, I acknowledge that participating in programs, classes or services sponsored by Nevada Childhood Cancer Foundation may expose me to possible risk of personal injury. I am fully aware of this risk and hereby release Nevada Childhood Cancer Foundation, its staff, board members, event sponsors or volunteers from any and all liability, negligence, or any other claims arising from or in any way connected with my participation in programs, classes, and services sponsored by Nevada Childhood Cancer Foundation. I agree to hold Nevada Childhood Cancer Foundation harmless for any personal injury, property damage, negligence, or any other loss arising out of participation in programs, classes or services sponsored by Nevada Childhood Cancer Foundation.

As a participant I am expected to behave respectfully and in a non-discriminatory manner. I understand that my privilege of being a participant may be revoked at any time at the sole discretion of Nevada Childhood Cancer Foundation.

I understand that it is my responsibility to consult with my doctors prior to and regarding my participation in programs, classes, or services provided by or sanctioned by Nevada Childhood Cancer Foundation and that if I have or have had cancer, a Physician's Approval Form is required for Massage Therapy, Reflexology, Craniosacral Therapy and Shiatsu. It is my responsibility to notify The Nevada Childhood Cancer Foundation and The Caring Place if there is a change in my health and my physician no longer approves the above-mentioned services. If I change doctors, it is my responsibility to obtain a new Physician's Approval Form and present it to Nevada Childhood Cancer Foundation and The Caring Place.

My signature is binding to this liability waiver from this day forward and verifies that I read and understand this form.

Last Name (print)_____ **First Name** (print)_____

Address_____City_____State_____Zip_____

Home Phone:_____ Cell Phone: _____

SIGNATURE:_____ DATE:_____

If under **18 years**, parent or legal guardian must sign.
Parent or Legal Guardian's Signature:_____ DATE:_____

Form Update: 6/5/17

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Cancer Foundation

CONSENT FOR PHOTOGRAPHS, RECORDING, FILM AND/OR PUBLICATION

I hereby authorize Nevada Childhood Cancer Foundation to photograph or record or permit other persons to photograph or record me while participating in a Nevada Childhood Cancer Foundation event and sponsored programs. Nevada Childhood Cancer Foundation may use and permit other persons to use the media prepared from such photographs or recording for such purposes and in such a manner as either may deem appropriate.

I agree the photographs, recordings, or videos may be used for purposes including but not limited to physicians, health professionals, and members of the public for educational, public relations, foundation advertisements and charitable purposes and that such dissemination may be accomplished in any manner. I understand that this agreement is being entered into to assist educational, public relations, and charitable goals and I hereby waive my right to compensation for such uses by reason of the foregoing authorizations, and my successors or assigns hereby release and hold the Nevada Childhood Cancer Foundation (and each and every one of its affiliated companies, officers, directors, employees, agents, representatives, licensees, and advisors) and assigns harmless from and against any claim for injury or compensation resulting from activities authorized by this agreement. I will not receive financial or in-kind compensation in exchange for using or disclosing of the photographs, recordings, or resulting media. The term "photograph" as used in the foregoing agreement, shall mean record, film, photograph, in any format including still photography, motion picture, video tape, video disc, social media platforms, and any other mechanical means of recording and producing images or sounds. I understand that I have the right to request cessation of photographing or recording at any time.

Name:_____

Street Address:_____

City:_____ST:_____ZIP:_____

Phone: _____

Signature:_____Date:_____

If under **18 years**, parent or legal guardian must sign.

Parent or Legal Guardian's Signature:_____ DATE:_____

Form Update: 6/5/17

Participant Conduct

The Caring Place was created as a sanctuary for adults diagnosed with cancer, cancer survivors, and their caregivers. Any form of conduct which detracts from a relaxing, stress-free, supportive, and enriching atmosphere will not be tolerated.

As a participant of The Caring Place (TCP), you are responsible to follow TCP rules and guidelines of conduct:

1. TCP is a smoke-free facility and smoking is prohibited in TCP and on TCP property. There are no designated smoking areas.
2. Gossip and harsh language toward others is a form of bullying and will not be tolerated
3. Class and Workshop supplies are the property of TCP and provided at no charge during supervised activities. They are not the possessions of any volunteer or participant.
4. Any removal of TCP property or possessions will not be tolerated.
5. Participants will give their full and undivided attention to instructors and teachers during class and/or workshop instruction.
6. Disruption, disrespect, and harsh language in class and/or workshops to any participant or instructor will not be tolerated.
7. Individuals initiating disruption, disrespect, and/or harsh language (i.e. threats, swearing, name calling, or any verbiage deemed as negative by management) on TCP property will be asked to leave immediately and not be permitted to return without the approval from Foundation management and after a three-month exclusion period. This time period may fluctuate at management discretion.
8. Instructors may appoint a volunteer or "helper" during classes and workshops. These are the only individuals permitted to assist the instructor according to the instructor's direction.
9. Photography, video, and the recording of others is not permitted in any therapeutic workshops, classes or events. Phones are to be stored appropriately and not used in these instances.
10. Participants will be respected who request NOT to be photographed in social classes and gatherings.
11. In respect to instructors and facilitators, participants are required to be arrive on time to classes and appointments. At the discretion of management, late arrivals may not be permitted to participate in class.
12. Discrimination will not be tolerated.

With your signature below, you acknowledge that you have read and agree to follow the Participant Conduct guidelines and understand that The Caring Place may refuse service if the above standards are not followed.

_____ _____

Participant Name – PRINT Date

_____ _____

Participant Signature Staff Initial

Form Update: 6/5/17

NON-OCOLOGY – MASSAGE INTAKE FORM

A Program of Nevada Childhood Cancer Foundation

NAME:_____ **DATE:** _____

EMERGENCY CONTACT PHONE#: _____

PLEASE CHECK, CIRCLE and COMPLETE where noted:

Have you ever had a Massage? ☐ YES ☐ NO

Describe your stress level:

0 1 2 3 4 5 6 7 8 9 10
No Stress Very Stressed

Describe your pain level:

0 1 2 3 4 5 6 7 8 9 10
No Pain Worst Pain

List current prescribed, over the counter medications, and alternative medications:

Medication	***For Condition***	***Side-effects***

SIGNS and SYMPTONS: Check appropriate box and add comments if you have or had any of the following:

Any swelling or tendency to swell anywhere in your body?_____NO ☐
Any sites or pain or tenderness anywhere in your body?_____NO ☐
Any sites of numbness /reduced sensation anywhere in your body?_____NO ☐
Skin conditions (rashes, infections, itching): YES ☐ NO ☐
Known allergies or sensitivities (use physician approved lotion on your skin and provide to massage therapist to use): YES ☐ NO ☐
Heart condition, high blood pressure, angina, hardening of the arteries, stroke, varicose veins, blood clots
Kidney failure, hepatitis, portal hypertension, etc.: YES ☐ NO ☐
Respiratory Conditions: YES ☐ NO ☐ Diabetes: YES ☐ NO ☐
Injuries to back, knee, disc, neck, recent fractures, or tendonitis: YES NO
Joint Problems: YES ☐ NO ☐ Digestive Problems: YES ☐ NO ☐ Surgery: YES ☐ NO ☐

_____
Participant Signature Date

_____
Therapist Signature Date

Updated 7/31/17