



Participant Registration

A participant is defined as a person who has a cancer diagnosis within the last 5 years or is currently in cancer treatment OR has lost a partner (direct day to day - caregiver) to cancer in the last 6 months.

**Notice: This form is to be used to register with the The Caring Place only.
PLEASE PRINT CLEARLY**

PRINT NAME (Last, First and Middle Initial): _____

Cell Phone: _____ **Home Phone:** _____ **Date of Birth:** _____
OK to leave a message? Yes ___ No ___

Address: _____

_____ **Email:** _____
City State Zip

Emergency Contact: _____ **Relationship:** _____ **Phone:** _____

Date of Cancer Diagnosis: _____ **Type:** _____

Do you have a caregiver? Yes ___ No ___

Name: _____ **Relationship:** _____ **Phone:** _____

A caregiver is defined as a person (paid or unpaid) who helps an individual with aspects of daily living that includes assisting with medication, bathing, dressing, meal preparation and doctor's appointments.

HEALTH INFORMATION:

Currently in Cancer Treatment: Yes/No Type: _____ Chemo _____ Radiation

_____ Alternative _____ Other Please explain: _____

Primary Physician: _____ Phone Number _____

Oncologist: _____ Phone Number _____

Do you have any other conditions that we should be made aware of? If so, please explain _____

Do you require a wheelchair? _____ Walker? _____

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: _____



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 with area code: (____) _____ - _____

Cell phone with area code: (____) _____ - _____

SIGNATURE: _____ DATE: _____

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

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



A Program of
Nevada Childhood
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 the 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, 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: _____

Updated 4/12/18

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. Shirts, shoes, pants, and casual/professional attire is acceptable. (Sports bras, bathing suits and attire meant for specialty classes or outdoor wear is NOT acceptable.)
4. Direction from NCCF staff members is to be respected.
5. 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.
6. Any removal of TCP property or possessions will not be tolerated.
7. Participants will give their full and undivided attention to instructors and teachers during class and/or workshop instruction.
8. Disruption, disrespect, and harsh language in class and/or workshops to any participant or instructor will not be tolerated.
9. 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 will 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.
10. 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.
11. 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.
12. Participants will be respected who request NOT to be photographed in social classes and gatherings.
13. 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.
14. 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



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Cancer Foundation

ONCOLOGY CLIENT – NTAL MASSAGE INTAKE FORM

NAME: _____ DATE: _____

Diagnosis Date: _____ Type of cancer: _____

Emergency Contact Name & Phone #: _____

PLEASE CHECK, CIRCLE and COMPLETE where noted:

Have you had Massage? YES NO

Are you in Treatment? YES NO Date of your last treatment? _____

Where was the cancer located? _____

Did treatment include removal or radiation of lymph nodes? YES NO

If YES, please describe location on your body: _____

List TREATMENTS undergone: _____

List TYPES OF SURGERY and Dates:

_____ Date: _____

_____ Date: _____

_____ Date: _____

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

Do you have site restrictions? Mark all that apply:

Incisions IV Skin sensitivity, rash/skin condition
Open wounds Port Ostomy
Drains or Dressings Catheter Other device: _____

Do you have pressure restrictions due to history or risk of lymphedema? Mark all that apply:

Tumor site Neuropathy Fatigue History/Risk blood clots
Radiation Site Bone/Spine metastasis Infection/fever Phlebitis
Anticoagulants Steroid medication Surgery Area of pain/burning
Low platelet count Fragile Veins Sensitive skin Area of infection

OTHER, Please Describe: _____

PRINT YOUR NAME: _____

Do you have position restrictions?

Incision

Tumor site difficulty breathing

Medication

Swelling or risk of swelling

Ostomy

Body areas needing elevation: _____

Medical Devices, please describe: _____

Any Discomfort, please describe: _____

Has cancer or cancer treatment affected any of the following body functions?

Lungs Heart Blood Counts Nervous System Liver Kidney Energy Level

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

Medication

for Condition

Side-effects

Medication	for Condition	Side-effects

SIGNS and SYMPTOMS: 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

Phone #

Therapist Signature

Date



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Physician's Approval for Adult Participants

My Patient (print patient's name): _____ D.O.B: _____

was diagnosed with (print cancer diagnosis) _____

on the following date _____ and has my approval to receive the following Healing Arts services that I have marked:

Yes No

- MASSAGE THERAPY** - Light to medium pressure to increase circulation & release stress
- Spurgeon Method™** - Breast & upper torso massage to relieve pain, reduce edema & increase ROM
- Lymphatic Therapy**- Gentle massage that moves lymph fluids around the body
- REFLEXOLOGY** -Light manipulation of feet to relieve stress
- SHIATSU** - Finger pressure massage which includes stretching to help with tight muscles

Physician's Signature

Date

Physician's Name Printed

Office Address

Phone No.

If you are in treatment, this approval form **must** be signed by your medical oncologist.

It is my responsibility, as a participant of The Caring Place, to notify The Caring Place if there is a change in my health and my physician no longer approves the above marked services for me. If I change doctors, it is my responsibility to obtain a new form and present it to The Caring Place.

Participant's Signature

Phone

Date

THIS FORM MUST BE FAXED FROM YOUR ONCOLOGY OFFICE TO THE CARING PLACE

The Caring Place is a program of Nevada Childhood Cancer Foundation, a 501 (c) 3 non-profit organization. All services are offered free of charge. The Caring Place is located at 3711 E. Sunset Rd., Las Vegas, NV 89120
Tel: 702.871.7333 **Fax: 702. 735.8431** www.nvccf.org **Form Update** 10/22/2020