RETURN TO

Keep Kids Connected
P.O. Box 14
Mont Belvieu, TX 77580

Keep Kids Connected
Connecting to the Power of Social Healing
www.keepkidsconnected.org

Application for Netbook/Tablet Computer

Keep Kids Connected provides Netbook/Tablet computers to kids with cancer or other life-threatening illnesses to help them stay connected to family and friends while they are in the hospital undergoing their treatment. To apply, the applicant must be between 4 and 18 years of age and be in active treatment or ongoing medical follow up for cancer or other potentially life-threatening illness. ► Please remember to have your physician complete and sign the box at the bottom of this page. This information is confidential. ► Please complete and return this form to the address listed above. Questions? Email **keepkidsconnected@gmail.com** or visit **www.keepkidsconnected.org**.

Applications will be accepted and Netbook/Tablet computers provided to qualified applicants as funds become available. Applicants are limited to one Netbook/Tablet computer. ***(Please print legibly to prevent a delay in processing your application.)***

Patient First and Last Name _____ Date _____

Parent/Guardian First and Last Name _____

Home Address _____ City/State/Zip _____

County _____ Country _____

Home Phone ( ) _____ Work or Cell Phone ( ) _____

Email Address _____ Primary Language Spoken _____

Patient Information

Gender: ☐ Male ☐ Female Date of Birth _____

Ethnicity: ☐ Caucasian ☐ African American ☐ Asian ☐ Hispanic ☐ American Indian ☐ Other

Does the patient currently own a Netbook, iPad, Tablet, or laptop for his/her own personal use? ☐ Yes ☐ No

Have you visited **www.keepkidsconnected.org** to learn about our organization? ☐ Yes ☐ No

Parent Signature _____ **Date** _____

- To be completed by the patient's doctor –

** Please note: signatures must be original; stamps, photocopies, or initials will not be accepted.**

Patient Diagnosis _____

Date of Diagnosis _____ Is patient in active treatment and/or ongoing follow-up? ☐Yes ☐ No

Provider Name _____ Hospital/Clinic _____

Address _____ City/State/Zip _____

Phone _____ Email Address _____

Physician Signature _____ Physician License # _____