BLUE SKIES GUEST FAMILY CONSENT TO RELEASE INFORMATION

Patient Information/Medical Clearance Form

TO BE COMPLETED BY APPLICANT:

Child's Legal Name: _____ Retreat Date Requested: _____

I consent medical/psychosocial information be released to Blue Skies for the purpose of a Family Referral to attend the retreat and Medical Clearance for my child. _____no ____ yes

_____ _____

Please print full parent/legal guardian name Parent/legal guardian SIGNATURE and DATE

_____ _____

NAME/TITLE of RN/PNP/PA or MD Phone AND Email of Reference

Treatment Center (outpatient) : _____

Treatment Center City: _____ State: _____ Zip: _____

Phone: _____ FAX:_____

Oncologist: _____ MD Email:_____

Primary Nurse: _____ RN Phone: _____

RN Email:_____ RN Fax:_____

TO BE COMPLETED BY HEALTHCARE TEAM MEMBER:

Blue Skies offers weeklong family retreats to bring the hope of Christ to families living through the challenges of pediatric cancer. Our hope is that children who are sick will laugh and play; that siblings, who often compete with cancer, will feel cherished; and, that marriages and families will grow strong. While we are a Christian-based ministry, our retreats are available to families of any faith.

Part of the Guest Family application process is for them to receive medical clearance from their child's health care team. The family listed above has applied to attend and has given consent for you to release information that may help us in the selection/screening process. *(For more information on the Blue Skies program or the family selection process, please visit our website at www.WhereSkiesAreBlue.org or contact our office at 678-486-5585.)*

Please verify the contact information above and complete the information and on page 2. You will receive an email one week prior to the retreat confirming the patient's final clearance. Once your patient is cleared to attend the retreat, please contact us if there are changes preventing them from attending the retreat.

We greatly appreciate your time
completing and **SCANNING/EMAILING the form to melindamayton@gmail.com**
OR mailing the form to our office: Blue Skies, 1000 Whitlock Ave., Suite 320 #234, Marietta, Georgia 30064.

Patient Information/Medical Clearance Form

Patient Name: _____

Diagnosis: _____ Date of dx: _____

Is the patient on therapy? _____ Tx. completion date or projected date of completion: _____

Please list any implanted support devices (port, CVL, shunt, G-tube, etc.)

_____
_____
_____
_____

Please list any treatment or anticipated supportive care the child will be receiving during the retreat (chemo, labs, special feedings, oxygen, etc.)

_____
_____
_____
_____

Does the patient have challenges with balance or ambulation? Does the patient use a wheelchair/need wheelchair access? Please explain.

_____
_____
_____
_____

Please list any concerns, needs:

_____
_____
_____
_____
_____

MEDICAL CLEARANCE: The patient listed above is pre-approved with medical clearance to attend Blue Skies on the retreat date requested. (Final medical clearance will be given within two weeks of the retreat.)

MD/PNP/PA Name and Title: _____ Email: _____

Signature: _____ Date: _____ Phone: _____

For Blue Skies office use only::

Final medical clearance:: yes____ no____ Consenting MD/PA/PNP_____

Date of clearance_____ Most recent ANC (date) _____