Membership Form 2020

Child's Name: (first) ________________ *(last)* ______________________

Birthdate: ___________*d* ___________*m* ____________*y* *Gender:* _____________

Diagnosis: ____________________________ *Date Diagnosed* __________________

*On Tx*___ *Off Tx*___ *End of Tx Date* __________________ *Bereaved* ___________

Parent's name: *(first then last)* ____________________________________*Mother*____ *Father*____

Cell phone ___________________ *email* _______________________________

Parent's name: *(first then last)* ____________________________________ *Mother*____ *Father*____

Cell phone _______________ *email* __________________________________

Patient lives with: ____________________

Siblings: _______________________*Gender:* __________*Age:* ___________

_______________________*Gender:* __________*Age:* ___________

_______________________*Gender:* __________*Age:* ___________

Complete Mailing Address: ____

City: ________________ *Province:* _________ *Postal Code*______________

*****please note that we communicate with our member families through email*****
By providing your email, you are giving your express consent to receive emails from Candlelighters

Note: Candlelighters often takes photos and videos at our events and activities which may appear on social media platforms or other promotional materials. If you have any questions, please contact us.