REQUEST A PARENT MENTOR

Children's Mercy

First Name _____ Last Name _____ Primary Phone _____

Street Address _____ City _____ State _____ Zip Code _____

E-mail _____

Name of child with health needs/experiences _____ Child's Date of Birth _____

Child's Diagnosis (primary/secondary) _____

To help us coordinate the best match, please share any additional information or experiences (ie. tracheostomy, feeding tube, pump, surgeries, equipment, community resources, social/emotional, other)

_____

_____

_____

Preferred way to contact (phone, email, time of day) _____

Do you have other children in the home? _____Yes _____No

Please indicate your preference for a trained volunteer mentor to match:

_____ Has a child with the same or similar diagnosis Other _____
_____ Has a child about the same age as my child

RELEASE OF INFORMATION: I give permission for the Children's Mercy parent support program to release my name, telephone number and the information I have volunteered on this form to another parent who has been screened and trained for a parent match. I also understand that failure to participate in this program will not affect my child's care or treatment at Children's Mercy. I may end participation at any time by contacting the name and number below.

Signature _____ Date _____

Relationship to child _____

Please send form to:
Hollee Muller, MSW, LCSW
Hematology/Oncology/Bone Marrow Transplant Parent to Parent Program Manager
Children's Mercy
2401 Gillham Road
Kansas City, MO 64108
Phone: (816) 302-6808
Email: hamuller@cmh.edu