braintumour foundation OF CANADA

BRAIN wave

BrainWAVE Pediatric Support Program Membership Form

Welcome to the BrainWAVE program!
To be sure you don't miss out on any events or information; please complete this form for your family.

Last Name:____

Parent(s) or Guardian(s) Names: ____

Name of Child with Brain Tumour: ____________________ Date of Birth: ______________
Child must be 19 years of age or younger

Names of Siblings (with ages): ____

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Address: ____

City/Prov.: ____________________ Postal Code: ____________________

Home Phone: ____________________ Work Phone: ____________________

E-mail address: ____

Comments or information you would like us to be aware of: ______________________

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The following information helps us to best plan programs and services for everyone affected by a brain tumour. This section is optional and all information is kept confidential.

How did you hear about us? ☐ Advertising ☐ Poster ☐ Family Member/Friend ☐ Online

☐ Referral from Physician/HCP/Treatment Centre (specify if possible)____________________

☐ Other (specify if possible)____

Type of brain tumour: ☐ Malignant ☐ Non-Malignant ☐ Mixed ☐ Waiting for pathology
Specify type of brain tumour if possible:____

Return by email to sender or fax to: 519.642.7192

Photograph Note: Please note that photos may be taken as part of a BrainWAVE event or activity. You will be contacted if we would like to use a photo with your family. Should you wish your family's photo not be taken, please notify staff.

Brain Tumour Foundation of Canada respects your privacy. We protect your personal information and adhere to all legislative requirements with respect to privacy. We do not rent, sell, or trade our mailing lists. The information you provide will be used to assist us in delivering services and keeping you informed about the activities of Brain Tumour Foundation of Canada, including programs, services, special events, funding needs and opportunities to volunteer.

www.braintumour.ca 1-800-265-5106