

**RETURN TO**

**Keep Kids Connected**  
P.O. Box 1127  
Katy, TX 77492



**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](mailto:keepkidsconnected@gmail.com) or visit [www.keepkidsconnected.org](http://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](http://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 # \_\_\_\_\_