The most common viral respiratory panel (VRP) positivity was observed between 5 months and 208 months and the mean age was 85.49±61.73 months (median=81 months). Although 44.3% (n=43) of the patients presented in winter and 23.7% (n=23) in autumn, VRP positivity was more common in patients presenting in spring (n=43, 70%) and winter (n=22, 51.2%) seasons. When the VRP results of the patients were analysed; 50.5% (n=49) were positive; 39.2% (n=38) were monoinfection, 11.3% (n=11) were co-infection and 49.5% (n=48) were negative. When we looked at the VRP results, rhinovirus (hRV) was the most common virus with a frequency of 22.4% (n=11). Other viruses were Respiratory Syncytial Virus (RSV) A/B (14.2% n=7), Parainfluenza (14.2% n=7), Influenza (8.2% n=4), Coronavirus (8.2% n=4), Metapneumovirus (2.1% n=1), Mycoplasma pneumonia (6.1% n=3). Among the co-infections seen in a total of 11 patients, hRV and RSV A/B were the most common viruses accompanying other viruses with a rate of 63.6% (n=7). Among a total of 67 patients who were in various stages of CT and whose treatment was completed, the most common VRP positivity was seen in patients in the induction phase with a rate of 28.3% (n=19). Of the 12 patients with co-infection, 5 (41.6%) were in the induction phase. Cough (n=59 60.8%) and fever (n=47 48.5%) were the most common presenting complaints, accompanied by wheezing (n=17 17.5%), respiratory distress (n=11 11.3%), diarrhea/vomiting (n=9 9.3%) and muscle pain (n=9 9.3%). VRP was positive in 43.9% of patients presenting with fever. The most common hRV virus was found most frequently in spring and winter seasons. Viral respiratory infection positivity was most frequently seen in ALL (n=16 33.3%), second most frequently in Hodgkin’s Lymphoma (n=5 10.5%) and Neuroblastoma (n=5 10.5%). Among the patients, upper respiratory tract infection (URT) (74.2%, n=72) was more common than lower respiratory tract infection (LRT) (25.8%, n=25). The rate of LRT in co-infections (28.0%, n=14) was higher than the rate of URT (6.9%, n=5) and was statistically significant (p=0.021). When hemogram and biochemistry results were analysed, although neutropenia (50.5%) and lymphopenia (50.5%) were observed at a high rate in patients with positive VRI, they were not statistically significant when compared with VRP positivity. Of the patients with VRP positivity (50.5% n=49), 34.6% (n=17) required hospitalisation due to viral respiratory infection. Of the patients included in the study, 4 patients need intensive care unit due to bacterial pneumonia (Mycoplasma pneumonia and Pneumocystis jirovecii), bleeding into a mass (hepatoblastoma) and pericardial effusion (peripheral T cell lymphoma). In 7 patients whose chemotherapy duration was prolonged, the duration of treatment prolongation ranged between 4 and 60 days (mean 19.29±20.69 and median 10 days). No VRI-related mortality was observed among the patients during the follow-up period. **Conclusion:** Identification of respiratory viruses in pediatric hematology oncology patients contributes to the management of their primary disease.