

MEDICAL INFORMATION

Physician's Name _____

Physician's Address _____

Physician's City, State and ZIP _____

Phone Number (_____) _____ Fax Number (_____) _____

Name of Treatment Facility _____

Child Life Specialist's Name _____

Phone Number (_____) _____ Fax Number (_____) _____

PHYSICIAN'S STATEMENT & AUTHORIZATION

(Please note: Our authorization to contact the child's primary care physician is on the next page. If you have any questions regarding **a Wish with Wings** or wish to discuss this particular child in more detail, please call our office at [metro] 817-469-9474. Thank you for your assistance in granting this child's wish!)

Physician's Statement and Medical Authorization: I am aware that the above named youngster has requested a wish be granted by **a Wish with Wings**. This child is currently receiving treatment for a life-threatening condition and he/she currently has a reduced likelihood of reaching adulthood because of that illness. I have read the information provided in the "Wish Information" section (request information from parent/guardian) and feel there will be no problem granting any of the wishes indicated, providing the following conditions are met. I understand this permission can be withdrawn at any time should the need arise and **a Wish with Wings** will be notified in the event withdrawal is necessary. I also understand this medical authorization is valid only for 90 days from the date below and written re-approval may be necessary after that date. If the child's request is a trip, he/she has my permission to travel by airplane to his/her destination.

Physician's Signature _____ Date _____

Medical Condition / Diagnosis: _____

Date Diagnosed: _____

Current Physical Limitations: _____

Medical Requirements (Please check all that apply):

Physical Requirements

_____ Oxygen (liters per minute) _____

_____ Wheelchair Assistance

_____ Other (Please specify) _____

Dietary Requirements (Please specify) _____

Other Requirements (Please specify) _____

MEDICAL RELEASE

To grant your child's wish, we must contact his/her primary care physician to obtain information regarding his/her medical condition, which will enable us to serve your child to the best of our abilities. Please sign below to authorize your child's primary care physician to provide this information to **a Wish with Wings**. An "Authorization for Use/Disclosure of Protected Health Information" ("HIPAA") form will be sent to you upon acceptance of said wish.

I/We authorize my/our child's primary care physician to provide **a Wish with Wings** the information necessary to grant my/our child's wish. I am the natural parent or legal guardian of _____ with the authority to execute this authorization permitting **a Wish with Wings** to obtain the information requested in this wish Request Form. I/We further release, indemnify and hold harmless **a Wish with Wings**, its volunteers, officers, agents and employees from any damages, claims, causes of action, losses or liabilities arising out of the activities of **a Wish with Wings** with our family.

BOTH PARENTS/LEGAL GUARDIAN(S) MUST SIGN BELOW AND HAVE THEIR SIGNATURES WITNESSED

Parent/Legal Guardian's Signature

Witness Signature

Parent/Legal Guardian's Signature

Witness Signature

Signed this _____ day of _____, _____
Date Month Year

MEDIA RELEASE

The stories of our wish children as told to a newspaper, magazine, radio or television station, by video or slide presentation, on our Facebook page and/or website allow us to raise funds so more of our children may have their wishes granted. We ask your permission to share your child's story with the media and tell how *a Wish with Wings* has touched your child's life and those of your family. Please indicate in the statement below whether or not you grant your permission to share your story with the media.

I/We hereby _____ Do Give _____ Do Not give permission for *a Wish with Wings* to share our child's story and photograph in all of a Wish with Wings' promotional and educational materials.

BOTH PARENTS/LEGAL GUARDIAN(S) MUST SIGN BELOW AND HAVE THEIR SIGNATURES WITNESSED

Parent/Legal Guardian's Signature

Witness Signature

Parent/Legal Guardian's Signature

Witness Signature

Signed this _____ day of _____, _____
Date Month Year