Physician and Medical Information

All information will be kept confidential.

Hospital:

Clinic:

Physician

Physician's Name	Office Telephone	Fax	Email

Social Worker

Social Worker's Name	Office Telephone	Fax	Email

Child Life Specialist

Child Life Specialist's Name	Office Telephone	Fax	Email

Medical Release

All information will be kept confidential.

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 biological 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 guardians 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

P 817-469-9474 | **F** 817-731-3399 | AWWW.org
3751 West Freeway, Fort Worth, TX 76107

aWishwithWings®

Physician's Statement and Authorization

All information will be kept confidential.

I am aware that _____ 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 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 I understand this permission can be withdrawn at any time should the need arise and a Wish with Wings will be notified in the event withdrawal is necessary.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)

- ☐ Oxygen (liters per minute) _____
- ☐ Wheelchair Assistance
- ☐ Other (please specify) _____

Dietary Requirements (please specify)

Other Requirements (please specify)

Physician Comments

P 817-469-9474 | **F** 817-731-3399 | AWWW.org
3751 West Freeway, Fort Worth, TX 76107

aWishwithWings