



# Family Wish Forms Packet

**Return forms to:**

ASW Chicago  
PO Box 577248  
Chicago, IL 60657

**Fax to:** 1-314-228-9460

**Email to:** [wishcoordinator@aswchicago.org](mailto:wishcoordinator@aswchicago.org)



ASW-1

**MEDICAL INFORMATION RELEASE AUTHORIZATION**  
(To be completed by parents/legal guardians)

I/We hereby authorize \_\_\_\_\_ M.D. and/or  
\_\_\_\_\_(hospital) to release medical and other  
pertinent information contained in the records of \_\_\_\_\_  
(Child's name)  
whose home address is \_\_\_\_\_  
(Street address) (City)  
\_\_\_\_\_  
(State) (Zip)

to A Special Wish Foundation, Inc. for their consideration in granting the special wish of the above named child/adolescent.

This consent is subject to revocation at any time except to the extent that action has been taken in reliance thereon. This authorization and consent will also automatically expire either at the end of ninety days or upon the release of the information herein referred to, whichever first occurs.

\_\_\_\_\_  
(Witness Signature) (Parent/Guardian Signature) (Date)  
\_\_\_\_\_  
(Witness Signature) (Parent/Guardian Signature) (Date)  
\_\_\_\_\_  
(Witness Signature) (Guardian Signature) (Date)

If wish applicant is 18, 19 or 20 years of age, he/she must also sign this form.

\_\_\_\_\_  
(Date) (Signature of Wish Applicant)  
\_\_\_\_\_  
(Date) (Witness Signature)



### RELEASE OF LIABILITY

(To be completed by ALL participants in wish)

I/We, the undersigned \_\_\_\_\_ parents, \_\_\_\_\_ guardians, \_\_\_\_\_ custodians of \_\_\_\_\_, in consideration of the granting and/or being involved in (name of child/adolescent)

the granting of a wish for said child/adolescent and provision of funds, goods and/or services in carrying out said wish do hereby voluntarily assume all risk of accident or damage to myself/ourselves and/or the person of or property of myself/ourselves and/or said child/adolescent and do hereby release and discharge A SPECIAL WISH FOUNDATION, INC., its employers, employees, agents and trustees of any claim, liability or demand of any kind for or on account of any personal injury or damage of any kind sustained as the result of the granting or carrying out of said wish.

I/We further agree that A SPECIAL WISH FOUNDATION, INC., (hereinafter referred to as ASW) shall remain free from liability and the liability of ASW shall in no manner be affected by its participation in the execution and fulfillment of said trip and/or activity.

The undersigned hereby acknowledge that they have received the written authorization of:

\_\_\_\_\_, M.D. for the said child/adolescent to participate in said wish and that they will follow said physician's advice in connection therewith.

I/We have not been promised anything by any agent, servant, representative or employee of ASW, nor has any person(s) associated with ASW given any advice or counsel with respect to the advisability and risks associated with said trip and/or activity. In that regard I/we am/are relying solely upon the advice and information supplied

to me/us by \_\_\_\_\_, M.D. ASW is acting and has acted pursuant to instructions by me/us and or the above-named physician.

\_\_\_\_\_  
(Witness) (Date) (Parent's/Guardian's Signature)

\_\_\_\_\_  
(Witness) (Date) (Parent's/Guardian's Signature)

\_\_\_\_\_  
(Witness) (Date) (Other Participant's Signature)

\*If wish application is for adolescent who is 18, 19 or 20 years of age, he/she must also sign application.

\_\_\_\_\_  
(Witness) (Date) (Wish Applicant, if appropriate)



## APPLICATION FOR WISH CONSIDERATION

(To be completed by parents/legal guardians)

CHILD/ADOLESCENT County in which child resides \_\_\_\_\_

Name: \_\_\_\_\_ Male/Female Date of birth \_\_\_\_\_

Disorder: \_\_\_\_\_

Resides with: \_\_\_\_\_ / \_\_\_\_\_  
(Name) (Relationship to child)

Address: \_\_\_\_\_  
(Street) (City) (State) (Zip)

Email address: \_\_\_\_\_

Phone: (C) ( ) - (H) ( ) - (W) ( ) - Best time to call \_\_\_\_\_

<u>PARENTS/LEGAL GUARDIAN</u>	<u>PLACE OF EMPLOYMENT</u>	<u>DATE OF BIRTH</u>
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Father: _____	_____	_____
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Mother: _____	_____	_____
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Legal Guardian: _____	_____	_____
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Any Military, Scouts, Church, etc affiliation that you would like us to know about:

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Is custody **FULL** or **SHARED**? (Circle one) If shared, both parents must sign all forms in this packet or copy of Child Custody Order must be attached to this form.

OTHERS RESIDING IN CHILD'S HOME

Name (first – last)	Relationship to Child	DOB	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Continue to other side





**INFORMATION RELEASE AUTHORIZATION**

(To be completed by parents/legal guardians)

I/We \_\_\_\_\_, hereby acknowledge and represent we are  
the \_\_\_\_ (parents)/ \_\_\_\_ (legal guardians) of \_\_\_\_\_  
(Name of child/adolescent)

and hereby authorize A SPECIAL WISH FOUNDATION, INC. (hereinafter referred to as ASW), or any of its agents, employees, officers or volunteers to photograph, film and/or electronically record interviews with us or the above-named child/adolescent, as they shall choose. We further authorize ASW or any person or organization participating in the taking of said photographs, films and/or electronically recorded interviews to distribute now or any time in the future all or any of the said photographs, films and/or electronically recorded interviews to anyone, including the general public, and to magazines, newspapers, the worldwide web via ASW internet sites, television and radio stations, and/or any other organization or person which customarily presents information and/or news to the general public. I/We further authorize ASW to disclose to the general public, as well as to television and radio stations, newspapers and magazines, the worldwide web via the ASW internet sites, now or at any time in the future, the name of the above-named child/adolescent and to discuss any aspect of his/her physical and/or emotional condition. It is my/our understanding that by signing this Information Release Authorization form, any aspect of subject child's/adolescent's physical and/or emotional condition may become public information and that I/we no longer have control over the distribution of said information and acknowledge that said child/adolescent may learn of his/her condition through other persons and that his/her condition may become common knowledge. It is not necessary for ASW or any other person(s) or organization(s) to contact me/us prior to release of any of the said information to the general public.

_____	_____
(Date)	(Parent's/Guardian's Signature)
_____	_____
(Date)	(Parent's/Guardian's Signature)
_____	_____
(Date)	(Witness' Signature)
_____	_____
(Date)	(Witness' Signature)

If wish application is for adolescent who is 18, 19 or 20 years of age, he/she must also sign application.

_____	_____ / _____
(Date)	(Witness' Signature) (Signature of Wish Applicant)