Family Wish Forms Packet

Please Send Completed Forms To
Email: wishes@aswchicago.org
or
Fax: (312) 962-4442

P.O Box 577248
Chicago, IL 60657

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 six months or upon the release of the information herein referred to, whichever first occurs.

______________________________ ______________________
(Parent's/Guardian's Signature) (Date)

______________________________ ______________________
(Parent's/Guardian's Signature) (Date)

______________________________ ______________________
(Witness' Signature) (Date)

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

______________________________ ______________________
(Signature of Wish Applicant) (Date)

______________________________ ______________________
(Witness' Signature) (Date)

Email: wishes@aswchicago.org Fax: 1-312-962-4442 P.O. Box 577248, Chicago, IL 60657

RELEASE OF LIABILITY

(To be completed by wish family members)

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.

_______________________________________ _______________________________
(Parent's/Guardian's Signature) (Date)

_______________________________________ _______________________________
(Parent's/Guardian's Signature) (Date)

_______________________________________ _______________________________
(Witness' Signature) (Date)

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

_______________________________________ _______________________________
(Wish Applicant, if appropriate) (Date)

_______________________________________ _______________________________
(Witness' Signature) (Date)

Email: wishes@aswchicago.org Fax: 1-312-962-4442 P.O. Box 577248, Chicago, IL 60657

RELEASE OF LIABILITY

(To be completed by ALL other participants in wish)

I/we, the undersigned participants in consideration of the granting and/or being involved in the granting of a wish for

____and provisions of funds, goods and/or services in carrying
(name of wish child)

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.

____ ____________________________
(Participant #1 Signature) (Date)

____ ____________________________
(Participant #2 Signature) (Date)

____ ____________________________
(Participant #3 Signature) (Date)

____ ____________________________
(Witness' Signature) (Date)

Email: wishes@aswchicago.org Fax: 1-312-962-4442 P.O. Box 577248, Chicago, IL 60657

ATTENDING PHYSICIAN'S MEDICAL STATEMENT/AUTHORIZATION

(To be completed by child/adolescent's physician)

CHILD/ADOLESCENT

Name: ____ Age: ___________________________

Address: ____
(Street address) (City) (State) (Zip)

WISH: (1st Choice) ____

(2nd Choice) ____

(3rd Choice) ____

This section to be completed by physician:

Life Threatening Condition (s): ____

Other Diagnoses:____

Prognosis: ____

Extenuating Circumstances (i.e. quality of life, severity/worsening of child's condition)_______________________________________

____

Physical and/or health limitations (which might require special accommodations): ___________________________________

The above-named child/adolescent **does** ___/**does not** ___ **CURRENTLY** have a medical problem which may be considered to be life-threatening.

As the attending physician to the above-named patient, it is my opinion that he/she is physically able to be engaged in the type of activity involved in the above-stated wish, and able to travel to ____
(if applicable) on the approximate date of ________________________, 20___ in fulfillment of the above-stated wish. I have explained to his/her parent(s)/legal guardian(s) the risks (if any) involved both physically and emotionally, and have instructed them how to handle emergencies which may arise regarding the above-named and on whom to call in the event of such emergencies.

To the best of your knowledge, has this child/adolescent had a wish granted by this or any other organization?

Yes________ No_________

____________________________	____________________________	( ) - ________
(Witness)	(Physician's signature)	(Phone no.)
____________________________	____________________________	
(Address)	(Street address)	
____________________________	____________________________	
(Witness)	(City, state and zip)	

Email: wishes@aswchicago.org Fax: 1-312-962-4442 P.O. Box 577248, Chicago, IL 60657

APPLICATION FOR WISH CONSIDERATION

(To be completed by parents/legal guardians)

____
County in which child resides

CHILD/ADOLESCENT

Name:____Male/Female Date of birth__________________

Disorder:____

Resides with:____/____
(Name) (Relationship to child)

Address:____
(Street) (City) (State) (Zip)

Email address:_______________________________________

(C) ( ) - (W) ( ) -
Phone: (H) ( ) - Best time to call___________________________

PARENTS/LEGAL GUARDIAN	PLACE OF EMPLOYMENT	DATE OF BIRTH
Father:___________________________	_________________________________	_______________
Mother:__________________________	__________________________________	________________
Legal Guardian:____________________	__________________________________	_________________

Any Military, Scouts, Church, etc affiliation that you would like us to know about:

____

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

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.

____ ____________________________________
(Parent's/Guardian Signature) (Date)

____ ____________________________________
(Parent's/Guardian's Signature (Date)

____ ____________________________________
(Witness' Signature) (Date)

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

____ ____________________________________
Wish Applicant, if appropriate) (Date)

____ ____________________________________
(Witness' Signature) (Date)

Email: wishes@aswchicago.org Fax: 1-312-962-4442 P.O. Box 577248, Chicago, IL 60657