

Wish Application Form



Please complete the information below about the child you are nominating.

Make-A-Wish® grants wishes to children (age 3 to17) living with a life threatening illness.

First Name of Child:		Surname:		Age:
Date of Birth:		Address:		
<input type="checkbox"/> Male <input type="checkbox"/> Female		Town:		
		County:		
Home Tel No.		E-mail:		
Mobile No:		Mother/Father/Other (Please circle)		
Mobile No:		Mother/Father/Other (Please circle)		
Child's School & Class/Year				
Child's Illness:				
Date of Diagnosis:				
Current State of Child's Health:				
Can the child express a wish? <input type="checkbox"/> Yes <input type="checkbox"/> No				
Consultant's Name:				
Hospital:		Tel No:		
Has the child had a wish before?		<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't Know		
If yes, give details:		How did you hear about Make-A-Wish®:		
List below all family members living with the nominated child, i.e. Parents, Brothers, Sisters:				
Name (inc.surname)		Relationship to child:		*Date of birth
				*Age

(*Required)

We/I confirm that the information above is complete & true, to the best of my knowledge. We/I, the Child's Parent(s)/Guardian authorise Make-A-Wish® to obtain all medical information about the Child which Make-A-Wish may feel necessary for consideration or fulfilment of the wish and authorise all physicians and medical care providers including the Child's Physician, to provide Make-A-Wish with all medical information regarding the Child. If my/our child is eligible for a wish, I/we agree that a copy of this application may be sent to the Make-A-Wish volunteer assigned for contact details or to other organisations that may assist with the wish.

Parent's / Legal Guardian's Name:	Signature:	Date:
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Notes- (office use only)
