

TROOP C TROOPERS ASSOCIATION

GRANT-A-WISH PROGRAM

P.O. Box 607, Schriever, LA 70395

(985) 448-3459

RELEASE OF INFORMATION

TO: _____
(Name of Doctor or Medical Facility)

This will serve as your authority to release and furnish to a representative of the Troop C Grant-A-Wish Program, P.O. Box 607, Schriever, LA, 70395, medical information including medications, diagnosis, prognosis or other information concerning

_____ This information is needed because
_____ has requested that the Troop C Grant-A-Wish Program _____

THUS DONE AND SIGNED THIS _____ DAY OF _____, 20____, AT
_____, LOUISIANA.

PARENT/LEGAL GUARDIAN (SIGNED)

PARENT/LEGAL GUARDIAN (PRINTED)

WITNESS: _____

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To be used by the TROOP C GRANT-A-WISH PROGRAM Board of Directors interviewing the applicant family.

CHILD'S NAME: _____ SEX: _____ AGE: _____ PH#: _____

ILLNESS OR CONDITION: _____

SPECIAL EQUIPMENT OR MEDICATION BEING USED: _____

AMBULATORY: YES _____ NO _____

PARENTS OR LEGAL GUARDIANS: _____

MAILING ADDRESS: _____

EMPLOYER: FATHER: _____ PH#: _____

MOTHER: _____ PH#: _____

EMERGENCY CONTACT: _____

ADDRESS: _____ PH#: _____

TOTAL NUMBER OF UNMARRIED CHILDREN AT HOME: _____

NAME: _____ AGE: _____ SEX: _____

NAME: _____ AGE: _____ SEX: _____

NAME: _____ AGE: _____ SEX: _____

NAME: _____ AGE: _____ SEX: _____

NAME: _____ AGE: _____ SEX: _____

NAME: _____ AGE: _____ SEX: _____

ATTENDING PHYSICIAN: _____

ADDRESS: _____ PH#: _____

PREFERRED DESTINATION OF TRAVEL: _____

PREFERRED DATES OF TRAVEL: _____

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DOCTOR'S RELEASE FORM

REFERRED: _____ DATE: ____/____/____

TELEPHONE: _____

CHILD'S NAME: _____ AGE: _____

CHILD'S DREAM (INCLUDE CHILD'S DREAM FORM): _____

ADDRESS: _____

MOTHER'S NAME: _____ PHONE: _____

WORK: _____ PHONE: _____

FATHER'S NAME: _____ PHONE: _____

WORK: _____ PHONE: _____

DOCTOR'S NAME: _____ PHONE: _____

OFFICE ADDRESS: _____

CHILD'S ILLNESS: _____

NOTES ON VISIT WITH DOCTOR (SPECIAL NEEDS, APPROVAL, ETC.): _____

NOTES ON VISIT WITH PARENTS: _____

SPECIAL NEEDS (DOCTOR AT DESTINATION, ETC.): _____
