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: ☐ Male ☐ Female	Address: Town: County:	
Home Tel No.	E-mail:	
Mobile No: Mobile No:	Mother/Father/Other (Please circle) 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?	☐ **Yes** ☐ **No**	
Consultant's Name:	Hospital:	
Consultant's Secretary:	Tel No:	
Has the child had a wish before?	☐ **Yes** ☐ **No** ☐ **Don't Know**	
Social Worker (if applicable):	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:
Notes- (office use only)		