DATE……

CHILD'S NAME……..DATE OF BIRTH……..……

NAME OF PARENT/GUARDIAN APPLYING……..…..…

ADDRESS……..……

…… POSTCODE……..……

TEL NO: (DAY)……(EVE)…… EMAIL ADDRESS……..……

NATURE OF CHILD'S ILLNESS……..……..

……..……

CHILD'S DREAM (PLEASE GIVE 3 CHOICES IN ORDER OF PREFERENCE)

1. ……

2. ……

3. ……

I/WE CONSENT TO HOPES & DREAMS FULFILLING A DREAM FOR THE ABOVE CHILD.

I/WE AGREE THAT DETAILS OF THE CHILD'S MEDICAL CONDITION CAN BE DIVULGED TO HOPES & DREAMS BY THE DOCTORS CARING FOR HIM/HER.

SIGNATURE OF PARENT/GUARDIAN ……...

PLEASE GIVE DETAILS BELOW OF SIBLINGS AND THEIR AGES

……

CHILD'S GENERAL PRACTITIONER

NAME ……

ADDRESS……

TEL……

CHILD'S HOSPITAL CONSULTANT

NAME ……

ADDRESS……

TEL……

38 Somersby Gardens Redbridge Essex IG4 5EA Tel: 020 8551 0092
ruth@hopesdreams.org / shelley@hopesdreams.org