



APPLICATION FORM
All information given is completely confidential

Registered Charity No. 1020016 www.hopesdreams.org

CHILD'S NAME.....Date of Birth.....

NAME OF PARENT/GUARDIAN APPLYING.....

ADDRESS.....

.....POST CODE.....

TELEPHONE NUMBER (Day)..... (Evening).....

NATURE OF CHILD'S ILLNESS.....

.....

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

1).....

2).....

3).....

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

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

SIGNATURE OF PARENT/GUARDIAN

BROTHERS/SISTERS, NAME /AGE.....

CHILD'S GENERAL PRACTITIONER

CHILD'S HOSPITAL CONSULTANT

NAME.....

NAME.....

ADDRESS.....

ADDRESS.....

.....POST CODE.....

.....POST CODE.....

TELEPHONE NO.....

TELEPHONE NO.....

DATE.....

WHERE DID YOU HEAR ABOUT US?

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