



CHARITY NO: 1123662

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|---------------------|
| For office use only |
| DATE RECEIVED..... |
| ALLOCATED TO |
| 1..... |
| 2..... |
| DATE COMPLETED..... |

DREAM REQUEST

Any information provided will be completely confidential.
We cannot guarantee that we will be able to grant all dream requests.

PLEASE PRINT CLEARLY

CHILD'S NAME M/F..... DATE OF BIRTH/...../.....

PARENT/GUARDIAN'S NAME

PARENT/GUARDIAN'S TELEPHONE NUMBER(S)

E-MAIL ADDRESS

NAME OF (please circle) PARENT/GUARDIAN/CARER/TEACHER/OTHER COMPLETING THIS REQUEST:

.....

YOUR TELEPHONE NUMBER(S).....

HOW DID YOU HEAR ABOUT THE DREAM FACTORY?.....

CHILD'S ADDRESS.....

.....

NATURE OF CHILD'S ILLNESS.....

.....

CHILD'S DREAM (PLEASE GIVE UP TO THREE WISHES IN ORDER OF PREFERENCE)

1.....

2.....

3.....

I/WE WOULD LIKE A DREAM TO BE FULFILLED FOR THIS CHILD.

SIGNATURE OF PARENT/GUARDIAN

DREAM REQUEST – FURTHER INFORMATION

TO ENABLE US TO PROCEED WITH YOUR CHILD'S DREAM REQUEST WE REQUIRE SOME OR ALL OF THE FOLLOWING INFORMATION. INFORMATION NOT REQUIRED IS DELETED.

PLEASE GIVE BRIEF DESCRIPTION OF CHILD'S ILLNESS/DISABILITY

DETAILS OF MOBILITY AND SPECIAL NEEDS:

NAME AND ADDRESS OF GP:

NAME OF HOSPITAL CONSULTANT:

NAME AND ADDRESS OF HOSPITAL:

NAME AND ADDRESS OF THERAPIST/SPECIALIST NURSE/PLAY THERAPIST

MEDICAL RELEASE FORM

I _____

(PARENT/GUARDIAN/CHILD OVER 16 YEARS) HEREBY GIVE PERMISSION FOR

(CONSULTANT/DOCTOR/NURSE/THERAPIST NAME)

TO RELEASE TO THE DREAM FACTORY THE REQUIRED MEDICAL INFORMATION REGARDING

(CHILD'S NAME)

SIGNED: _____ PARENT/GUARDIAN/CHILD* (DELETE AS APPROPRIATE)

*IF A CHILD IS OVER 16 YEARS OF AGE THEY MUST FILL OUT THIS FORM THEMSELVES IF CAPABLE. WE CANNOT PROCEED WITHOUT THE ABOVE FORM BEING SIGNED.

PLEASE ENCLOSE A RECENT PHOTOGRAPH.

IF YOU REQUIRE HELP WITH THIS FORM PLEASE CALL: 07712 619726

PLEASE RETURN THIS FORM TO:

THE DREAM FACTORY
SOUTH EASTERN HOUSE
62-70 FOWLER ROAD
HAINAULT
ESSEX
IG6 3UT