MEDICAL AUTHORIZATION

PARENT/GUARDIAN: PLEASE SIGN THIS AUTHORIZATION AND GIVE FORM TO YOUR CHILD'S PHYSICIAN TO COMPLETE.
I authorize my child's physician to provide Sunshine Foundation the information requested below.

_____	_____	_____	_____
CHILD'S NAME	**DOB**	**PARENT/GUARDIAN SIGNATURE**	**DATE**

PARENT/GUARDIAN: DO NOT WRITE OR FILL IN ANY INFORMATION BELOW THIS LINE

PHYSICIAN: PLEASE RETURN COMPLETED FORM TO PARENT OR SCAN/EMAIL TO
PROGRAMSERVICES@SUNSHINEFOUNDATION.ORG

Sunshine Foundation answers the dreams of children, ages 3 -18, diagnosed with SEVERE or PROFOUND physical, developmental, or intellectual challenges, or trauma from *physical/sexual* abuse, and whose families cannot fulfill their requests due to financial strain that the child's illness may cause.
Although a "critical" or "life threatening" diagnosis is not required, the child's condition MUST be SEVERE or PROFOUND to qualify.

Please answer ALL 9 questions and return as quickly as possible. We are grateful for your assistance in helping us determine if child meets the medical criteria to receive a dream come true!

1. **DIAGNOSIS: _____**
2. **Child's diagnosis is: SEVERE ☐ PROFOUND ☐ *CRITICAL ☐ DX IS NOT SEVERE/PROFOUND☐**
   NOTE: At least one box above must be checked. *CHILD MAY QUALIFY FOR OTHER WISH-GRANTING ORGANIZATIONS THAT GRANT WISHES FOR CRITICAL ILLNESSES/DIAGNOSES.
3. **Is child diagnosed with a history of trauma *from physical/sexual* abuse? YES☐ NO☐**
4. **AUTISM Diagnosis – Child is diagnosed with LEVEL 3 "*Requiring very substantial support*"? YES☐ NO☐**
   NOTE: Child must be diagnosed with Level 3 AUTISM (SEVERE-PROFOUND) to qualify.
5. **Number of hospital admissions as result of his/her diagnosis _____**
6. **Number of surgeries _____**
7. **Should child's dream require travel:**
   a. **Is child permitted to travel on commercial airline? YES☐ NO☐**
   b. **Wheelchair required for child? YES☐ NO☐ If YES, please check: Collapsible ☐ Non-Collapsible ☐**
   c. **Nurse/aide or other medical professional required to accompany child? YES☐ NO☐**
   d. **Oxygen required? YES☐ NO☐**
   e. **Medical equipment required? YES☐ NO☐ If YES, pls list: _____**
8. **Has child received a wish from another wish granting 501c3 organization? YES☐ NO☐**
9. **Why would you recommend this child to have a dream through Sunshine Foundation?**

_____

x_____ _____
PHYSICIAN'S signature required **NPI # (National Provider Identifier number)**

x_____ _____
PHYSICIAN'S name (printed) **E-mail**

_____ _____
DATE **Phone**

PLEASE STAMP FORM TO VALIDATE ORIGIN OF INFO

07.08.22 MA update