Physician / Patient Summary

Child's Name:

Address:

City: State: Zip:

Date of Birth: Age:

Telephone:

Parents Names:

Attending Physician:

Physician's Telephone: Emergency:

Patient Information

Diagnosis:

Will the child require any medical services while they are participating in their "wish"? YES NO

If yes, please list:

Will the child require any of the following?

- Wheelchair (specify if electric):
- Oxygen (specify rate):
- Nursing Services:
- Transfusions
- X-ray
- Venous Access (physical location / type):
- Lab

Overall current medical condition of the child:

Current medications (list type/dosage):

Medications contraindicated:

Allergies:

On study:

Physician Signature: Date:

Medical Authorization

As the primary care physician for ______________________

{Print wish child's name}

I, ______________________ M.D., am familiar with the

{Physician's name}

physical condition of the above named child. I have explained to the above named child's parent(s) or legal guardian(s) the medical condition of the above named child. I have discussed with the parent(s) or legal guardian(s), the risks involved (both physically and mentally), by participation by the above named child in fulfillment of the wish (as it was explained to me and as hereinafter described). I have instructed them as to who to call in the event medical assistance is needed and how to handle medical emergencies.

As long as the parent(s) or legal guardian(s) take sufficient precaution to protect the above named child in accordance with my instructions to them, I am of the opinion that participation in the wish described to me by the above named child will not present medical risk to him/her sufficient to prevent my recommendation he/she participate in the following wish.

Description of Wish

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Mail to:
Benefit4Kids Outdoor Wish
21660 23 Mile Road
Macomb MI 48044