AUTHORIZATION & RELEASE

P: 727.896.6390 **F:** 727.896.6380 P.O. BOX 1881, ST. PETERSBURG, FL 33731
WWW.CHILDRENSDREAMFUND.ORG

I (We)_____, being the _____ of
(NAME OF PARENT(S) / GUARDIAN) (PARENT(S) / GUARDIAN)

_____, do hereby request the Children's Dream Fund to grant my (our)
(NAME OF CHILD)

child's dream set forth in the application submitted to the organization. I hereby authorize the Children's Dream Fund to contact my child's physician concerning my child's illness and authorize the physician to release any and all medical information concerning the child, necessary for the Children's Dream Fund to attempt to grant the child's dream. I (we) further release, indemnify and hold harmless the Children's Dream Fund, its volunteers, officers, directors, agents, servants and employees from any damages, claims, causes of action, losses or liabilities arising out of the activities of the Children's Dream Fund with parents/guardians, the child and anyone participating in the child's dream.

Signed_____, day of _____, 20_____

(BOTH PARENTS MUST SIGN) WITNESSES

_____ _____
MOTHER

_____ _____
FATHER

_____ _____
GUARDIAN (IF APPLICABLE)