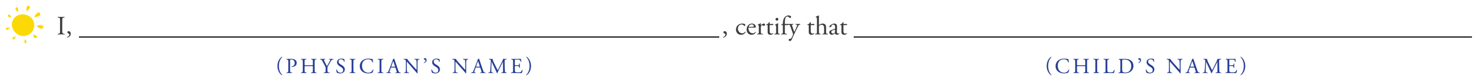
MEDICAL AUTHORIZATION

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

It is the mission of the Children's Dream Fund to make dreams come true for children with life threatening illnesses. We are aware that some chronic illnesses often do, in fact, have life threatening complications. We, therefore, ask that you please indicate where applicable what the complications are that would allow this child's illness to meet the criteria of life threatening. Thank you for helping us with this distinction.



I, ____, certify that ____
(PHYSICIAN'S NAME) (CHILD'S NAME)

has a diagnosis of: ____
(DIAGNOSIS AND COMPLICATIONS WHERE APPLICABLE)

and that he/she meets the criteria as set forward above.

________________________________ ________________________________ ________________________________
(PHYSICIAN'S SIGNATURE) (PRINT PHYSICIAN'S NAME) (DATE)

____
(PHYSICIAN'S OFFICE ADDRESS)

________________________________ ________________________________
(OFFICE PHONE) (EMERGENCY PHONE)

If you have any questions about this request please call the Children's Dream Fund at 727-896-6390.

Please FAX completed form to 727-896-6380.