



# 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](mailto: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

\_\_\_\_\_  
M.E. #

**X** \_\_\_\_\_  
PHYSICIAN'S name (printed)

\_\_\_\_\_  
E-mail

\_\_\_\_\_  
DATE

\_\_\_\_\_  
Phone

\_\_\_\_\_  
Fax

