Cherished Creations
"Helping to Create Better Lives"

Cover Sheet

DREAM WISH OR SPECIAL REQUEST APPLICATION INSTRUCTIONS

Dear Applicant:

Cherished Creations, Inc. is a nonprofit organization dedicated to improving the quality of life for children and young adults with life-threatening illnesses by helping to fulfill their dream wishes and special requests. In order to qualify for this program, children and young adults (21 years of age or under) must meet the Eligibility Criteria as shown on the attached.

In order to be granted the dream wish or special request, an application package must be submitted and approved by the Cherished Creations, Inc. Board of Directors.

For requests over $500, use the four-page application which consists of the following:

- Form 1 - The Application itself which must be filled out by a Social Worker or a Doctor at the hospital or clinic where the wish-recipient is being treated.
- Form 2 - An Attending Physician's Report which must be prepared by the child or young adult's attending physician.
- Form 3 - A Parent/Guardian Questionnaire which must be completed by the child or young adult's parent(s) or guardian.
- Form 4 - A Release Form which must be signed by the parent or guardian of the child or young adult and witnessed by two adults. If the child or young adult is 18 or older, they can sign the Release Form.

For Requests under $500, use the single Application Form (Form 5).

Please mail or fax the forms to Cherished Creations. In all cases, the fulfillment of a Wish depends on the availability of resources, i.e. tickets, space, budget, etc.

During the review process, Cherished Creations, Inc. may request additional information as needed. Please note, under any circumstance we do not reimburse for any wishes purchased at any time throughout our process. If there are any questions or concerns, please call 908-790-0511 or e-mail us at dpwhitney@cherishedcreations.com

Sincerely,

Doreen Whitney
Director of Program Services
Fax: 908-790-0522

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DREAM WISH OR SPECIAL REQUEST APPLICATION *FORM 1*

CHILD /YOUNG ADULT'S NAME _____ DOB: ____/____/____
(Please Print Clearly)

ADDRESS: _____City_____State _____Zip_____

MOTHER'S NAME: _____ _____ TEL #: (_____) _____
(Last) (First)

FATHER'S NAME: _____ _____ TEL #: (_____) _____
(Last) (First)

GUARDIAN'S NAME: _____ _____ TEL #: (_____) _____
(If applicable) (Last) (First)

E-MAIL ADDRESSES: _____ _____
Parent/Guardian Child/Young Adult

DIAGNOSIS:_____ DATE FIRST DIAGNOSED:: ____/____/____

HOSPITAL: _____

ADDRESS: _____City_____State _____Zip_____

PHYSICIAN: _____ TEL # (_____) _____

SOCIAL WORKER: _____ TEL # (_____) _____

Has child or young adult received a "wish" from another organization? Yes _____ No _____

Date: _____Please provide details: _____

If so, what qualifies him/her for another wish at this time ?_____

CURRENT WISH REQUEST: Please *describe child's/young adult's wish in detail, using additional paper if necessary.*

APPLICATION SUBMITTED BY: (Please print) _____ DATE: _____

"RELATIONSHIP TO" OR "ROLE WITH" APPLICANT: _____ TEL #:(____)_____

E-MAIL ADDRESS: _____

343 Snyder Avenue, Berkeley Heights, NJ 07922 Tel. (908) 790-0616 Fax (908) 790-0522

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DREAM WISH OR SPECIAL REQUEST *FORM 2*
ATTENDING PHYSICIAN'S REPORT

CHILD'S NAME: (Please Print) _____ AGE:____ DOB:: ____/____/____

DIAGNOSIS: _____ DATE of DX. ____/____/____

IS ILLNESS LIFE-THREATENING? YES _____ NO _____

PROGNOSIS AT THIS TIME: GOOD _____ GUARDED _____ POOR _____

CURRENT TREATMENT: _____

Are you aware that this child or young adult has requested a dream wish or special request?

Yes _____ No _____ Please describe dream wish or special wish: _____

_____

Does the child or young adult have any restrictions that might hinder the fulfillment of this request?

Yes _____ No _____ Please describe: _____

In your opinion, is the child or young adult's physical and/or emotional state adequate to fulfill dream wish or special request?

Yes _____ No _____ Please explain: _____

_____

Do you know if child or young adult has had a "wish" granted by another organization?

Yes _____ No _____ Please provide details: _____

Do you recommend that the child or young adult be granted their dream wish or special request?

Yes _____ No _____ Comments: _____

_____

ATTENDING PHYSICIAN'S NAME: (Please print) _____

HOSPITAL: _____

ADDRESS: _____City_____State _____Zip_____

ATTENDING PHYSICIAN'S SIGNATURE: _____

DATE: _____ TEL #: (_____) _____ E-MAIL Address_____

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DREAM WISH OR SPECIAL REQUEST *FORM 3*
PARENT/GUARDIAN QUESTIONNAIRE

CHILD'S NAME: (Please Print) _____

RESIDES WITH: _____ RELATIONSHIP TO CHILD: _____

ADDRESS: _____City_____State _____Zip_____

TELEPHONE #: (Home) (_____)_____ (Work) (_____)_____ (Cell)_____

Which phone can we call during daytime hours?_____

MOTHER'S NAME: (Please print) _____

FATHER'S NAME: (Please print) _____

GUARDIAN'S NAME: (Please print) _____
(If applicable)

ATTENDING PHYSICIAN: _____ TEL #: (_____) _____

ADDRESS: _____City_____State _____Zip_____

Are there other immediate family members residing in the home? Yes _____ No _____

NAME	RELATIONSHIP TO CHILD	AGE
_____	_____	_____
_____	_____	_____
_____	_____	_____

Who has custody of child or young adult?:

MOTHER/FATHER: _____ MOTHER: _____ FATHER: _____ GUARDIAN: _____

Has child or young adult ever had a "wish" granted by another organization? Yes _____ No _____

Please explain: _____

Do you have any reservations about news/media coverage? Yes _____ No _____

Please explain. _____

Does the child or young adult know the seriousness of their illness? Yes _____ No _____

Please advise us how we should handle the possible disclosure of the illness if a situation develops where it needs to be revealed? _____

If we need to send a package that requires a signature, to what name and address should we send it?

Name: _____ Phone # _____

Address _____

Cherished Creations

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CHERISHED CREATIONS WISH RELEASE *FORM 4*

I, the undersigned parent/guardian of _____ (hereafter referred to as the "child"), or participant (if applicable), in consideration of the granting and/or being involved in the granting of a dream wish / special request for the child described as follows: _____ _____, on behalf of myself and/or the child, do hereby assume all risk of injury, death, damage, loss or other harm, to myself and/or the child, or to our property, and do release, discharge and hold harmless Cherished Creations, Inc., its trustees, offices, employees, volunteers and other agents, from and against any and all claims, liabilities, damages, costs, expenses (including attorneys' fees and costs) and other losses of any kind, economic or otherwise, direct or indirect, known or unknown, sustained as the result of the carrying out of the dream wish/special request, as described in this Release.

I further authorize Cherished Creations, Inc., or any of its trustees, offices, employees, volunteers and other agents, to photograph, film, tape and/or digitally record interviews with me, the child and/or other immediate family members, or the activities in which we engage as part of the dream wish / special request, in its sole discretion, without any charge or payment to us. I also authorize Cherished Creations, Inc., or any person or organization participating in the taking of photographs, films, tapes or digital recordings covered by this Release, to distribute now or any time in the future all or any of said photographs, films, tapes or recordings to anyone, including the public, through all forms of media, including, without limitation, magazines, newspapers, television, radio, Internet or any other form of media, for the purpose of promoting Cherished Creations, Inc., its fundraising events and activities, and its charitable mission, without any charge or payment to me. I also authorize Cherished Creations, Inc. to disclose to the public, through all forms of media as described above, or in any other manner, now or at any time in the future, the name of the child and to discuss any aspect of his/her physical and/or emotional condition.

It is my understanding that, by signing this Release, any aspect of the child's physical or emotional condition may become public information and that I no longer have control over the disclosure of this information. I also acknowledge that the child may learn of his/her condition through other persons and that his/her condition may become common knowledge. It is not necessary for Cherished Creations, Inc. or any other person(s) or organization(s) to contact me prior to the release of any information covered in this Release to the public.

I acknowledge that, if applicable, an authorization from the child's treating physician, for the child to participate in the dream wish/special request as described above, has been obtained. I further acknowledge that I have reviewed this Release with an attorney, or have had the opportunity to do so prior to its execution. I have relied upon both the treating physician and counsel in connection with the acceptance of the dream wish / special request and this Release, and not on any statements made by Cherished Creations, Inc. or any of its trustees, offices, employees, volunteers or other agents.

CONTINUE

I HAVE READ THE FOREGOING RELEASE, FULLY UNDERSTAND ITS TERMS, ACKNOWLEDGE THAT I HAVE GIVEN UP SEBSTANTIAL RIGHTS BY SIGNING IT, AND SIGN IT FREELY WITHOUT ANY INDUCEMENT.

(Mother/Father/Guardian's Name - Print) (Signature) (Date)

(Mother/Father/Guardian's Name - Print) (Signature) (Date)

If child or young adult is age 18 or older, he/she too must also sign here:

(Name - Print) (Signature) (Date)

Additional participants in dream wish / special request must also sign here:

(Name - Print) (Signature) (Date)

(Name - Print) (Signature) (Date)

(Name - Print) (Signature) (Date)

Two witnesses must sign and provide their addresses:

(Name - Print) (Signature) (Date)

Address: _____ City _____ State _____ Zip _____

(Name - Print) (Signature) (Date)

Address: _____ City _____ State _____ Zip _____