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# WISH REQUEST FORM

Any information provided will be treated completely confidentially. We cannot guarantee that we will be able to grant all wish requests.

**PLEASE PRINT CLEARLY**

CHILD'S NAME ....................................................................................................................

Male/Female DATE OF BIRTH ....../..../.......... (DD/MM/YYYY)

AGE of CHILD: ………………..

PARENT/GUARDIAN'S NAME...............................................................................................

PARENT/GUARDIAN'S CONTACT NUMBER:.......................................................................

E-MAIL ADDRESS...............................................................................................................

NAME OF PERSON COMPLETING THIS REQUEST:

......................................................................................................................................

RELATIONSHIP TO CHILD:....................................................................................................

CONTACT NUMBER............................................................................................................

HOW DID YOU HEAR ABOUT US.........................................................................................

CHILD'S
ADDRESS..........................................................................................................................
......................................................................................................................................
............................................................................................POSTCODE

NATURE OF CHILD'S
ILLNESS.............................................................................................................................
......................................................................................................................................
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CHILD'S WISH:

......................................................................................................................................

I/WE WOULD LIKE A WISH TO BE FULFILLED FOR THIS CHILD.
SIGNATURE.........................................................................................................................

**WISH REQUEST – FURTHER INFORMATION**

TO ENABLE US TO PROCEED WITH YOUR CHILD'S WISH REQUEST WE REQUIRE THE FOLLOWING INFORMATION:

PLEASE GIVE BRIEF DESCRIPTION OF CHILD'S ILLNESS/DISABILITY:

DETAILS OF MOBILITY AND SPECIAL NEEDS:

NAME AND ADDRESS OF GP: :…………………………………………………………………….
………………………………………………………………………………………………………………………………………………
……………………………………………………………………………………………………………………………………………
………………………………………………………..

NAME OF HOSPITAL CONSULTANT: ……………………………………………………………

NAME AND ADDRESS OF HOSPITAL:………………………………………………………….
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NAME AND ADDRESS OF THERAPIST/SPECIALIST NURSE/PLAY THERAPIST
………………………………………………………………………………………………………………..
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**MEDICAL RELEASE FORM**

I ___________________________________________________________________
(PARENT/GUARDIAN/CHILD OVER 16 YEARS) HEREBY GIVE PERMISSION FOR

___________________________________________________________________
(CONSULTANT/DOCTOR/NURSE/THERAPIST NAME) TO RELEASE TO THE MCA TRUST THE REQUIRED MEDICAL INFORMATION REGARDING
___________________________________________________________________
(CHILD'S NAME)

SIGNED: __________________________________________ PARENT/GUARDIAN/CHILD*
(DELETE AS APPROPRIATE)

*IF A CHILD IS OVER 16 YEARS OF AGE THEY MUST FILL OUT THIS FORM THEMSELVES IF CAPABLE. WE CANNOT PROCEED WITHOUT THE ABOVE FORM BEING SIGNED.

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**WHAT TO DO NEXT:**

PLEASE SEND YOUR SIGNED AND COMPLETED FORM, TOGETHER WITH A RECENT PHOTOGRAPH OF THE CHILD, TO:

THE MCA TRUST
97 High Road
Orsett
Essex
RM16 3LD

IF YOU NEED ANY HELP FILLING IN THIS FORM OR HAVE ANY QUESTIONS, please call us on 07771 554 015 or email us at enquiries@mcatrust.org.uk