Dreams Come True of Louisiana, Inc.
P. O. Box 1252
Youngsville, LA 70592
phone: 225-341-3484 fax: (225) 341-1222 www.dctofla.com

A non-profit organization granting dreams to Louisiana children with life-threatening illnesses

Application For Dream

Has this child received a dream before: Yes ☐ No ☐

Child's name: _____ **Age:** _____ **DOB:** _____ ☐ Male ☐ Female

Illness or condition: _____

Parents or guardian(s): _____
Last Name First Name Middle Initial

_____
Last Name First Name Middle Initial

Address: _____ Louisiana
Street/P.O. Box City **State** Zip Code

Home Phone: ( ) _____ **Work Phone:** ( ) _____ **Other Phone:** ( ) _____

Shirt Size: _____

E-Mail: _____

Where did you hear about DCT _____

Referred by _____

Emergency Contact other than listed above

Name of emergency contact: _____ **Telephone #:** ( ) _____

Address: _____ **Relationship:** _____

Name of treating Physician: _____ **Telephone #:** ( ) _____

Address: _____
Street/P.O. Box City State Zip Code

We, the undersigned, understand that *Dreams Come True of Louisiana, Inc.* is under no obligation to do anything other than to consider this application. We hereby grant our consent to *Dreams Come True of Louisiana, Inc.* to contact persons listed above for the sole purpose of assessing need. We also provide our consent to the physician listed above to release all relevant medical records for the Applicant in connection with this application.

We ☐ do ☐ do not, consent to news coverage and/or promotional advertising that may arise in fulfilling this Dream and/or promoting *Dreams Come True* of Louisiana, Inc. organization.

We certify that this child has not been granted a dream by *Dreams Come True of Louisiana, Inc.*or any other organization.

_____ _____ _____
Father/Guardian (Signature) Mother/Guardian (signature) Date

Treating Physician's Report

Patient's name: _____ Age: _____ ☐ Male ☐ Female

_____ _____

Name of treating physician (please print) Signature of treating physician

1. Is this life threatening? ☐ Yes - ☐ No
2. Diagnosis and staging or extent of disease: _____

_____

- ☐ Is He/She undergoing treatment? – _____
- ☐ Is unresponsive to treatment? ☐ Is responsive to treatment _____
- ☐ No treatment at this time. _____

3. Does this child have a chance of attaining a cure? ☐ Yes - ☐ No
4. Estimated chance of surviving five years: ☐ 75% ☐ 50-75 ☐ 25-50% ☐ 25%
5. Current or planned treatment: _____

_____

6. Current functional status:
7. Is applicant ambulatory? ☐ Yes ☐ No – Special equipment or medication(s):_____

☐ Fully active with little or no symptoms.

☐ Moderate limitation of normal activity for a child of his/her age.

☐ Major limitation of activities or very symptomatic.

☐ Other – please explain: _____

8. How would expected side effects of treatment interfere with this child's function? _____

_____

_____

9. Additional remarks or comments: _____

_____

_____ _____

Mother's/Guardian Signature Father's/Guardian Signature