

Dreams Come True of Louisiana, Inc.

P. O. Box 1252

Youngsville, LA 70592

phone: 225-614-8197 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 or working with another organization: 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

Mom Cell Phone: () Dad Cell 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:** _____

