



Battle for a Cure Foundation

On the next page, you will find the application for the Battle for a Cure Foundation Christmas Program. Please note the permanent changes to this program as of 01/17/2015.

Please read the instructions carefully before filling out the application.

Who Is Eligible:

- >Any child currently fighting cancer or any other life threatening disease under the age of 18 is welcome to enroll.
- >Any child up to three (3) years in remission is welcome to enroll.

Program Changes:

- >**The Christmas Program is only available for the Christmas holiday.** With the Christmas Program, your family will receive One (1) Gift Card in the amount of \$50 (fifty dollars) to be mailed to your provided address before Christmas Day to help pay for your family's needs during Christmas.
- >You are required to fill out a new Christmas Program Form during every year that you wish to participate (paperwork will not "carry over"). Your child's health professionals must also sign a new form every year. Every form must be completed in its entirety or it will NOT be accepted (this includes an email address for us to contact you).

To be included in the 2017 Christmas Program, we must receive your new form by OCTOBER 31, 2017.

If you have any questions at all, please email Amanda@battle4acure.org.



Application for the Battle for a Cure Foundation Christmas Program

(This form is to be completed by the child's PARENT/LEGAL GUARDIAN ONLY - PLEASE PRINT)

Fighter's Name: _____

Age: _____ DOB: _____ Gender: Male Female

Parent/Legal Guardian Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Parent Email Address: _____

I understand that my family will receive One Gift Card in the amount of \$50 to help with Christmas expenses. The Gift Card will be mailed to me at the address provided above.

(please initial here)

(This form will NOT be accepted unless you check the box and agree to the statement below.)

By signing this application, I am agreeing to ALL of the following:

- Possible publication of my child's name, medical history and photos by the Battle for a Cure Foundation.
- I am allowing my child's medical professionals and the Battle for a Cure Foundation permission to share medical information about my child.

*Parent/Legal Guardian Signature

Date

**Application for the Battle for a Cure Foundation Christmas Program
MEDICAL INFORMATION**

(This form is to be completed by your child's MEDICAL PROFESSIONAL ONLY.)

Fighters Name: _____

Child's Diagnosis: _____

Date of Diagnosis: _____

Child's Physician: _____

Hospital: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Contact: _____ Phone: _____

Please describe the child's current medical condition:

Name and Title (Please Print) Signature

Date Social Worker's Email Address

***Please make sure this ENTIRE Application is complete before submitting it.
Incomplete applications will NOT be accepted.**

For questions or concerns please email Amanda@battle4acure.org
Please mail completed application (both pages) to the address below:
Battle for a Cure Foundation
402A W. Palm Valley Blvd. #101
Round Rock, TX 78665