Battle for a Cure Foundation

On the next page, you will find the application for the Battle for a Cure Foundation Hope Box Program. Please note the permanent changes to this program as of 01/17/15.

Please read the instructions carefully before filling out the application.

Who Is Eligible:

>Children 18 and under who have been diagnosed with terminal cancer. If there is any question about your child's health status, please consult your doctor before filling out the paperwork. This program is only available to children who are considered to have a "terminal" health status by their medical physicians.

>Siblings under the age of 17 are welcome into the program with their fighter sibling's paperwork.

Program Details:

>Your family will receive One Hope Box upon the arrival of your completed paperwork.

>The Medical Information page MUST be completed by a Medical Professional ONLY.

>You must include a working email address in the Parent Email Address field, so we can contact you about your child's box.

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

Application for the Battle for a Cure Foundation Hope Box 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: _____

Sibling #1	Sibling #2	Sibling #3
Name: _____	Name: _____	Name: _____
DOB: _____	DOB: _____	DOB: _____
Gender: Male Female	Gender: Male Female	Gender: Male Female

(Please add additional Siblings to the bottom of this page.)

Address: _____

City: _____ State: _____ Zip Code: _____

Parent Email Address: _____

{Additional Option:}

☐ Please share my child's updates on the Battle for a Cure Foundation Facebook Page.

(By checking this box allowing us to post your child's updates to our Facebook page, you are giving us permission to post prayer requests, pictures and information about your child to our public Facebook page for all to see. Your address will NEVER be shared by our organization.)

My Child's Caringbridge/Facebook/Other Link: _____

(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 Hope Box 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