



## Battle for a Cure Foundation National Gift Card Program

**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 Guidelines:

>**The National Christmas Program is only available for the Christmas holiday.** With the National 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).

>If you are local to Austin, TX or any surrounding areas, please contact Amanda before signing up for this program. We offer a much larger Christmas Program for local families.

**To be included in the 2019 Christmas Program, we must receive your new form by NOVEMBER 1, 2019.**

If you have any questions at all, please email [Amanda@battle4acure.org](mailto:Amanda@battle4acure.org).



**Application for the Battle for a Cure Foundation National 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 (with permission).
- 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 National 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](mailto: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**