MEG'S SMILE FOUNDATION

REQUEST FOR A SMILE

CONFIDENTIAL

APPLICANT INFORMATION		
Name:		
Date of Birth:	Age:	Phone:
Current Address:		
City:	State*:	ZIP Code:
Boy ◯ Girl ◯ (Please circle)	E-mail:	
Website/Facebook Page/Support Website:		
Parent/Guardian Name #1:		
Parent/Guardian Name #2:		
Applicants hobbies, likes, favorite teams, etc (MSF likes our Smiles to be as personalized as possible): This information will be used to create the smile. Please be as specific as possible.		
Sibling #1 & Age:	Sibling #2 & Age:	Sibling #3 & Age:
Sibling #4 & Age:	Sibling #5 & Age:	Sibling #6 & Age:

MEDICAL INFORMATION (CONFIDENTIAL)	
Diagnosis & Prognosis:	How long since diagnosis?
Hospital/Clinic providing treatment (Name and State*):	
Doctor Name:	
Phone:	E-mail:
Address:	
City:	State: ZIP Code:
Child Life Specialist/Social Worker:	
Phone:	E-mail:
Person referring Applicant (if other than Parent/Guardian) Name:	
Phone:	E-mail:

ADDITIONAL INFORMATION

Other Charitable Organizations Providing Assistance:

Important Note: Unfortunately, we have been notified by Make-A-Wish (MAW) that receiving as Smile from Meg's Smile Foundation prior to receiving a wish from MAW would disqualify you from receiving a wish from MAW. If you plan to have a MAW in the future, you may want to consider waiting for a Smile until after the MAW is finalized.

Parent/Guardian Initials: _____

*Applicant must be a resident of NC or must be under medical treatment in NC to qualify for a Smile

This document contains information which will be kept confidential and only used or disclosed as the Foundation deems necessary so the Foundation can make a determination of Smile eligibility and to provide a personalized Smile. Sometimes it may be necessary to request additional information. Meg's Smile Foundation thanks you for taking the time to provide this important information. If you have any questions, please contact us at the e-mail address or phone number below.

We/I confirm that the information is complete and true to the best of my knowledge. We/I authorize Meg's Smile Foundation to obtain medical information about the Child which MSF may feel necessary for consideration of the Smile. We/I understand that we/I may be required to sign a waiver at the time of the Smile event.

Parent/Guardian Name:	**Signature:**	**Date:**

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