MEDICAL CONSENT FORM

Dreamz4u require your permission to contact your child's GP/Consultant in order to confirm that we can carry out a specific dream and obtain more details regarding their medical condition.

Child's Name____

Please give details of GP/Consultant:

Name____

Address____

____

Telephone Number ____

Please complete details below:

I ____(parent/guardian/child) confirm that I

give my permission for the above named GP/ Consultant to release information on (nominated

child's name)____medical condition.

Signature ____(parent/guardian/child*)

Date ____

*If a child is over 16 years of age they must fill out this from themselves.

The Dream application will not be considered without this form being signed and sent to:

Dreamz4u, Suite G2/3, Faraday Business Centre, 34 Faraday Street, Dundee, DD2 3QQ

Should you have any queries about this form please call 01382 836886

www.dreamz4u.org