GIFTING PROGRAM FORM

Please complete this form so that we can customize your child's gift.

The following information is required for the Package of Hope and Celebrating Hope gift requests.

Package of Hope – This gift is for a child aged 0-19 who has been recently diagnosed with cancer.

Celebrating Hope – This gift is for a child who will be INPATIENT during their birthday.

Patient Information:

Favorite Color: ______________________________

Favorite Cartoon/TV Character: ____________________

Favorite Sport/Sports Team: __________________

Favorite Activity/Hobby/Interest: ___________________

Favorite Snack/Candy: ______________________

Favorite Stores to shop: ___________________________

Favorite Cake Flavor: ☐ Vanilla ☐ Chocolate ☐ Strawberry

Favorite Cake Icing: ____

Clothing Sizes: Shirt: _____________ Pants: _________________ Shoe/Slipper: _________________

Please tell us all the beautiful things we should know about your warrior to help us customize their gift.

____

____

____

____

____

____

____

____

The following information is required for our Beauty of Hope gift request.

Beauty of Hope – This gift is for teen patients aged 13-19 in active treatment. **MUST be approved by Oncologist.**

Name of Salon/Spa: ____ Website Address: ______________________________

City: _____________________________________ State: **NJ** Zip Code: _____________ Phone Number: _________________

Please select one option: ☐Manicure ☐Pedicure ☐ Mini-Facial ☐ Massage

GIFTING PROGRAM FORM (continued)

Child's Name: ____

Our mission at Sarah's Fight for Hope is to be able to provide support to as many families of children battling cancer as possible. Private donations fund our programs, allowing us to continue bringing smiles to kids with cancer.

You can help increase awareness of pediatric cancer and show our donors the impact of their contribution by submitting a picture of your child and a testimonial of how our gift has impacted your child.

Please consider submitting a headshot of your child with your application and a few words of appreciation that we can share with our donors who make our programs possible. ***A picture is worth a thousand words.***

AUTHORIZATION/RELEASE FORM

For Parent/Legal Guardian and Patient:

This shall serve to authorize Sarah's Fight for Hope Foundation, Inc. to utilize, publish or otherwise expose photographs, drawings, or any other likeness or image and any biography, story, or any additional information provided regarding (child's name) __________________________*. Should the child be a minor, the legal guardian will sign to report to the Trustees or for a press release or display at fundraising events or any online presentation on Sarah's Fight for Hope Foundation page or Sarah's Fight for HOPE Foundation website.

* By signing this application, you are attesting to the accuracy of the information on all pages of the submitted application. Fraudulent applications may result in your application being deemed ineligible for this program. Please be sure that the entire application is complete before submitting it. Incomplete applications will be returned to you.

Parent/Legal Guardian Name (print) ____

Parent/Legal Guardian Signature: ________________________________**Date:** __________________________

Patient's Signature (age 18 and over): ____

For Social Worker

By signing this application, you are attesting to the accuracy and validity of the Patient and medical information provided, including MD approval for the Beauty of Hope gift.

Social Worker's Name (print) ____

Social Worker's Signature: ____ **Date:** ____________________