Gifting Program Form

Please complete this form so that we can customize your child's gift
Please email completed form to programs@sarahsfightforhope.org

Grants limited to NJ residents only

Personal Contact Information:

Patient's Name: _____ DOB:_____ Gender: ☐ M ☐ F

Mother's Name: _____Father's Name: _____

Address: _____City:_____ State: NJ Zip: _____

Home Phone: _____ Cell Phone: _____

Email Address: _____

Preferred Method of Contact: ☐ Home Phone ☐ Cell Phone ☐ Email

Medical Information:

Diagnosis: _____Date of Diagnosis: _____

End of Treatment Date: _____

Treating Hospital: _____

Full name of Social Worker:_____ Email: _____

Social Worker's Direct phone/extension: _____

Which gift Program are you applying for? (please check one)

☐ Package of Hope: This gift if for a child, age 0-19 who has been diagnosed within six months of request

☐ Celebrating Hope: This gift is for a child who will be inpatient during their birthday

☐ Beauty of Hope: This gift is for teen girl age 13-19 in active treatment. Receive a gift certificate for a local spa/salon for a manicure, pedicure, teen facial or a massage. *Must have MD clearance for this service.*

☐ Adventure of Hope: A special request for a much-needed escape from the reality of cancer treatment and hospital visits. Options include Broadway shows, Sports Events, Concert Tickets; a wish that would be impossible for parents to provide without the help of an outside resource.

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The following information is required for Package of Hope and Celebrating Hope grants.

Patient Information:

Favorite Color: _____ Favorite Cartoon or TV Character: _____

Favorite Sport/Sports Team:_____ Favorite Activity/Hobby/Interest:_____

Patient's Favorite Candy/Snack: _____Patient's Favorite stores: _____

Clothes size: Shirt: _____ Pants: _____ Shoe/Slipper: _____

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

_____

_____

The following information is required for our Beauty of Hope grant.

Name of Salon/Spa: _____Website Address: _____

City:_____ State: NJ Zip:_____Phone Number: _____

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

The following information is required for our Adventure of Hope grant.

Requested Gift: _____

How will this gift benefit the applicant? _____

_____

_____

_____

Additional Family Information *(On occasion we like to recognize siblings for supporting their brother/sister during their battle. We know "No One Fights Alone" and it's important to us that siblings be recognized, and their spirits be lifted as well)*

Name of Siblings: 1) _____2) _____3) _____

Date of Birth of Siblings: 1) _____2) _____3) _____

Social Media:

Do you have any social media pages/links that journal your experience with pediatric cancer?

Facebook _____Caring Bridge _____

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Go Fund Me _____ Other _____

Authorization/Release Form

For Parent(s) 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 other information provided regarding patient name_____*. Should patient be a minor, legal guardian will sign for the purpose of reporting to the Trustees or for press release or display at fundraising events or any on line display 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, to the best of your knowledge. 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(s) signature: _____ **Date:** _____

Patient's signature (age 18 and over): _____

**For Sarah's Fight for Hope to continue granting special gifts to all our pediatric cancer warriors, it is important for us to share pictures and testimonial from your gift experience. This allows us to share with our generous donors to ensure we continue to have their support for our various programs.*

We would greatly appreciate it if you would email us at programs@sarahsfightforhope.org, and let us know how your special gift/program was and share some pictures with us.

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 Beauty of Hope grant.

Social Worker's Name (print) _____

Social Worker's Signature: _____ **Date:** _____