Kristie's FOUNDATION
FOR CRITICALLY ILL CHILDREN

Compassion Request

Child's Name:_____ Age:____ Sex:_____ Birth Date:_____

Theme Park Requested : _____ Date of visit: _____

Child's Illness: _____

Doctors Name:_____ Phone Number:_____

Is a Wheelchair or stroller Needed at theme park? _____

FAMILY INFORMATION

	Last Name	First Name	Participating in Request?
Mother:	_____	_____	☐ Yes ☐ No
Father:	_____	_____	☐ Yes ☐ No

Address: _____

City, State Zip Code: _____

Cell/Pager:_____ Home Phone: _____

Email Address:_____

Primary language of the family:___ _____

Who has legal custody? ☐ Mother ☐ Father ☐ Both ☐ Guardian

NOTE: Only immediate family members and nurse will be complimentary. (Parents or Guardians, and siblings under the age of 21 living in the same household) Call for all other guests!

First Name	Last Name	Age	Date of Birth	Relationship
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

COMPLETE ALL BLANKS AND Email to compassion@Kristies.org