APPLICATION FOR PARTICIPATION

Dream Weavers is a non-profit Colorado Organization making it possible for children ages 2-18 with life threatening illnesses to experience the joy of dream come true.

Written application should be made on the form provided and sent to:
Dream Weavers of Southern Colorado - Post Office Box 212 - Pueblo, Colorado 81002
For information: **Phone - 719-553-9559.**

The following criteria are to be utilized in considering all applications:

1. Applications must be made on the application form provided and must be signed by the appropriate parent or legal guardian and the child's treating physician.

2. Application will be accepted on behalf of children who are residents of Southern Colorado; however, other applications may be accepted and reviewed on a case-by-case basis.

3. Applications will be accepted on behalf of children ages 2 to 18 with life threatening illness.

4. Applicants will not be discriminated against on the basis of race, color, religion or sex.

5. Applications will be referred to and reviewed by Dream Weavers Board Members. The application forms will be filled out by parents and physician. Applications may be require to submit supporting medical information to the Dream Weavers Board including medical records and written reports from treating or consulting physician. Whether or not to approve the application for the child and family to be part of the Dream Weavers Organization shall be the sole discretion of the Dream Weavers Board of Directors.

6. After the application has be approved the Dream Director will schedule a **Family Orientation** which will be scheduled during a board meeting (meeting are held the 2nd Monday of the month). Board members will explain what Dream Weavers Organization dreams and events include. It will also give families a chance to ask questions about the organization.

7. Applications will be acted upon and applicants will be notified pre phone call as to whether or not the application has been approved or rejected within sixty days after receipt of the application of Dream Weavers of Southern Colorado.

8. If you have any questions or concerns please call 719-553-9559

***Attached application forms that must be filled out completely and signed by the parent or legal guardian and the child's treating physician.**

APPLICATION FORM

DREAM WEAVERS OF SOUTHERN COLORADO

Post Office Box 212 - Pueblo, Colorado 81002
Phone:719 553-9559

1. Name of parents / legal guardian and Date of Birth:_____

2. Address of parent / legal guardian: _____

3. Home Phone Number of parents / legal guardian: _____

4. Father's Cell Phone:_____ *Mother's* Cell Phone:_____

5. Name of Child: _____ Date of Birth:_____

6. Emergency Contact Phone Number (not one listed above):_____

7. Illness or Condition: _____

8. Name and Address of child's treating Physician: _____

9. Telephone Number of child's treating Physician: _____

10. Please list immediate family members under the age of 18, living in child's home (*Names & Date of Birth*)

_____ _____ _____

_____ _____ _____

11. Short Statement of Child's Dream_____

_____

12.I authorize Doctor_____ to release to Dream Weavers of Southern Colorado any and all medical information it may deem necessary to consider the application for participation in the Dream Weavers Program.

_____ _____ _____

Parent / Legal Guardian Today's Date Date Application was Received by Board

Dream Weavers Publicity Guidelines in order for Dream Weavers to fulfill its mission of dreams come true for children with potentially life threatening illnesses participants in the Dream Weavers program must understand and agree to the following conditions:

1. Some publicity relating to the participant's dream is necessary in order for Dream Weavers to receive the funds and services required to fulfill the dream.
2. Dream Weavers will make every attempt possible to protect the participant and the participant's family or guardian from unsolicited harassment by screening offers of help and other attempts to contact the family.
3. No statement regarding the medical condition of a Dream Weavers participant will be released by Dream Weavers without approval of the organization's medical advisor or your permission. Any releases will contain only a general description of the diseases/illness with the expression "potentially life threatening" (if applicable). Chances or odds of survial will not be used and the word "terminal" will not be used.
4. All publicity will be handled by the Dream Weavers publicity committee.

If_____ is a participant in the Dream Weavers program I agree to the above conditions for publicity

_____ _____

Signature of Parent/Guardian Today's Date

ATTACHED TO BE COMPLETED BY CHILD'S TREATING PHYSICIAN

Dream Weavers

Dream Weavers is a non-profit Colorado Organization making it possible for children ages 2-18 with life threatening illnesses to experience the joy of dream come true.

TO BE COMPLETED BY CHILD'S TREATING PHYSICIAN

1. Child's name:_____

2. Date began treating child:_____

3. Diagnosis:_____

4. Is this child's diagnosis a life threatening illness?_____

5. Should this child's dream be granted as soon as possible_____

6. Current Condition:_____

7. Additional Remarks: _____

_____

_____

_____ _____

Signature of Treating Physician Today's Date

This application was _____Approved _____Rejected at the Dream Weavers Screening Committee; Meeting of _____.
(DATE)

The applicant was notified of this decision pre phone call on_____
(Date)

_____
DREAM WEAVERS BOARD MEMBER