



Make A Child Smile Organization

www.makeachildsmile.org
a 501(c)(3) tax-exempt organization
EIN: 88-0433621

NEW FEATURED CHILD MEDICAL VERIFICATION FORM

To be completed and **SIGNED** by the child's Doctor, Head Nurse OR Social Worker.
Please **PRINT CLEARLY** and FAX completed form to (866) 498-9772 (no cover sheet needed)

Child's Full Name: _____

Child's Date of Birth: _____

Child's Main Diagnosis: _____
(Full medical name for diagnosis is needed - i.e. "Acute Lymphoblastic Leukemia" NOT just "Leukemia")

Child's Secondary Diagnoses: _____
(if any)

Please answer the following questions: **** PLEASE TYPE OR PRINT CLEARLY ****

1) Is the condition/illness that this child was diagnosed with and is currently under treatment for, considered to be life-threatening?

2) Is this child's condition/illness currently under control by treatment and/or medication?

3) Are surgeries anticipated to correct or treat the child's condition/illness?

Name of Doctor, Head Nurse OR Social Worker (underline one): _____

Name of Hospital or Clinic: _____

Contact Phone: _____

SIGNATURE of Doctor/Nurse/Social Worker named above: _____

We may contact you if additional information or clarification is needed regarding this patient.

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