# Parental Release For Requesting Medical Verification From Attending Physician

**We must have this Release and Verification from the Attending Physician in order to process the application.**

The Child's name is: ________________________________ Child's D.O.B________________

Child's Social Security Number: ______________

The Child's attending physician is: ____________________________________________________________

Physician Name: ____________________________________________________________________________

Physician Address: __________________________________________________________________________

City: ____________________________ State or Province: _________ Zip or Postal Code: _____________

Phone (______) ____________________ Fax: (______)___________________

May we contact the attending physician for medical verification? ☐ Yes ☐ No

**RELEASE**: If yes, please sign the following: ***I have granted Catch-A-Dream Foundation permission to contact my child's attending physician regarding the health status of my child and hereby grant permission for the physician to release the requested information to Catch-A-Dream Foundation.***

________________________________________________________
Parent or Guardian Name

________________________________________________________ Date: ____________________
Parent or Guardian Signature

**Return SIGNED FORM to:** **OR** FAX to: 662-324-5699

Catch-A-Dream Foundation
2485 Ennis Rd.
Starkville, MS 39759

**OR**

Scan and email signed form to:
**george@catchadream.org**
**spencer@catchadream.org**