



PRECIOUS TOUCH FOUNDATION INC.

P.O. Box 814, Bridgetown, Barbados. W.I.  
Phone: (246) 423-7863, Mobile: (246) 230-3402  
Email: precioustouch@hotmail.com

Corporate Tax No. 29818

**CHILD REFERRAL FORM**

YOUR FIRST NAME: \_\_\_\_\_ YOUR LAST NAME: \_\_\_\_\_

YOUR RELATIONSHIP TO CHILD: \_\_\_\_\_

NAME OF CHILD: \_\_\_\_\_  
(SURNAME) (FIRST) (OTHER NAMES)

SEX: MALE  FEMALE  DATE OF BIRTH: \_\_\_\_\_  
(DAY/MONTH/YEAR)

REASON FOR REFERRING CHILD: \_\_\_\_\_

**Contact Information**

**PARENT/GUARDIAN 1**

NAME \_\_\_\_\_  
(SURNAME) (FIRST) (OTHER NAMES)

ADDRESS \_\_\_\_\_

PLACE OF EMPLOYMENT \_\_\_\_\_

TELEPHONE NUMBERS \_\_\_\_\_ (H) \_\_\_\_\_ (W) \_\_\_\_\_ (OTHER)

**PARENT/GUARDIAN 2**

NAME \_\_\_\_\_  
(SURNAME) (FIRST) (OTHER NAMES)

ADDRESS \_\_\_\_\_

PLACE OF EMPLOYMENT \_\_\_\_\_

TELEPHONE NUMBERS \_\_\_\_\_ (H) \_\_\_\_\_ (W) \_\_\_\_\_ (OTHER)

**Other Information**

ATTENDING PHYSICIAN \_\_\_\_\_ TELEPHONE NUMBER \_\_\_\_\_

ADDRESS \_\_\_\_\_

YOUR TELEPHONE NUMBER \_\_\_\_\_ EMAIL: \_\_\_\_\_ YOUR SIGNATURE: \_\_\_\_\_

**FOR INTERNAL USE ONLY**

DATE OF REFERRAL: \_\_\_\_\_  
(DAY/MONTH/YEAR)

ACCEPTED  DECLINED

WISH EFFECTIVE DATE: \_\_\_\_\_  
(DAY/MONTH/YEAR)

ACCEPTED BY: \_\_\_\_\_

*...Making Precious Wishes Come True...*



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### PARENTAL AND MEDICAL CONSENT FORM

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This is to certify that we the undersigned parents/guardians, hereby consent and grant permission for our son/daughter/ward ..... to participate in the "Wish" granting program of **Precious Touch Foundation Inc.**

#### I consent and grant permission

- i. for the release of all necessary information pertaining to the said child by the attending physician(s) and/or medical institution(s) to the Precious Touch Foundation Inc. to determine whether the particular "Wish" can be executed safely and to assess the medical eligibility of the said child for the stated "wish" and
- ii. that upon approval of the said wish that the Precious Touch Foundation Inc. shall have the right to utilize any information secured during the wish granting process for promotional purposes, including but not limited to, publications, photographs, voice and video recordings but **excluding confidential medical information.**

The granting of a wish is at the sole discretion of the Precious Touch Foundation Inc. Wishes pertaining to financial assistance for medical conditions shall not be granted by The Precious Touch Foundation Inc.

Signature(s): .....

Name(s) of Parents/Guardians: .....

.....

Date: ..... Telephone:..... Email: .....

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**MEDICAL CONFIRMATION FORM**

Based on my assessment and the medical records presented to me,  
.....is/is not diagnosed with a life threatening medical condition, and therefore qualifies/does not qualify to participate in the "WISH" granting program with **PRECIOUS TOUCH FOUNDATION INC.**

Signature .....Official Stamp

Name of Medical Practitioner:- .....

Date:- .....Telephone:.....Email:.....

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