## **Austin Wade Foundation Application for Assistance**

Today's Date:	
Name of Parent (s):	
Name of Child:	Date of Birth :
Age of Child:	Gender of Child:
Address:	
Phone Number:	Alternate Phone Number:
Date of Diagnosis:	<del></del>
Diagnosis of Child: _	
Current Treatment Pla	n:
Treating Physician: _	
Treatment Facility: _	
Tell Us About Your C	hild (Attach additional paper if needed.):
Signature of Parent(s)	:
_	

- \* Child must be under the age of 18 and currently battling cancer.
- \* Additional information may be requested.
- \* Media release form is enclosed.

Application may be mailed to: Austin Wade Foundation

210 Scout Cabin Road Carterville, IL 62918

~ NO ONE FIGHTS ALONE ~

<sup>\*</sup>Must be a Southern Illinois resident.

<sup>\*</sup> Please attach written confirmation from treating physician, or social worker who is currently familiar with the child and their diagnosis.