CONFIDENTIAL

BERT'S BIG ADVENTURE APPLICATION

COMPLETED APPLICATIONS SHOULD BE MAILED TO:

Bert's Big Adventure
Application Dept.
PO Box 420917
Atlanta, GA 30342-0917

What is Bert's Big Adventure?

Bert's Big Adventure (BBA) is a 501 (c)(3) non-profit organization that provides a spectacular five day journey to Walt Disney World for children with a chronic or terminal illness and their families. This trip and the year round programs that follow each adventure allow participants to establish lasting friendships with others facing similar challenges, experience events and venues that otherwise could not be afforded, and enjoy the gift of intimate family time together where the focus turns from living with an illness to making magical moments.

All applications must be postmarked by ***November 5, 2010*** *to be accepted. You will be notified by mid December 2010 as of the status of your application. A faxed or photocopied version of the application is not acceptable. An original copy of the application must be mailed. Only the medical questionnaire can be faxed.*

Prior to completing this application, please refer to the following requirements:

The child you are nominating must be between the ages of 5 and 12 years old, or will be at the time of the trip (2/2011).

The child you are nominating has never been to Walt Disney World.

Without the help of BBA, the child/family you are nominating does not have the financial means available to afford a trip to Walt Disney World. Families may be asked to verify income through previous tax returns.

DO NOT STAPLE APPLICATION PAGES

A parent or legal guardian must complete and sign this application

Date of Application: ____

Part 1: **Nominated Child's Information**

Name of Child: ____ Male or Female

Address of Child: ____
Street Address Apt. # City/State/Zip Code

Home Phone: ____________________________________ Birth Date: _______________________
MM/DD/YYYY Age

Name of Child's School: ____

Grade Level: ____________________ Name of Child's Teacher: ____________________________

T-Shirt Size: ____________________

Part 2: **Parent or Legal Guardian's Information**

Name of Person Completing Application: ____

Relationship to Applicant: ____

Address if Different from Child: ____
Street Address Apt. # City/State/Zip Code

Home Phone: __________ Cell: __________ Work Phone: __________ Email: _________________

Other Parent/Guardian Contact Information:

Name: ____

Home Phone: __________ Cell: __________ Work Phone: __________ Email: _________________

With Whom Does the Child Currently Reside: Both Parents ____ Mother____ Father ____
Legal Guardian ____ Other _____

Is English the parents' first language? Yes __________ No __________

Name of Mother's Employer: ____

Name of Father's Employer: ____

Annual Household Income: ____

Emergency Contact Information – Someone other than parent/legal guardian listed above.

Name: ____

Home Phone: __________ Cell: __________ Work Phone: __________ Email: _________________

Part 3: Information Regarding Child's Medical Condition

What is your child's diagnosis? ____

Please give a short description of your child's illness: ____

____

____

Please give a short description of the medical treatment/attention your child is currently receiving:

____

____

____

What do you have to do to care for your child? ____

____

Does your child have any travel restrictions? Yes ____ No ____ If yes, please explain: ____________________

____

Please list any medications your child is currently taking: ____

____

Does your child require special medical equipment such as: Wheelchair ______ Walker ______ Other ______

If your child requires a wheelchair, is it: Manual ________ Electric ________ Wheelchair Weight __________

Does your child require the wheelchair: All the time _____________ For Distance Only _________________

Does your child require oxygen? Yes ______ No ______ If yes: As needed: ________ Continuous _______

Does your child require any specialized medical care that must be provided by a nurse or physician on a daily basis? Yes _____ No ____ If yes, please explain: ____

____

Name of child's primary care pediatrician: ____

Phone number of primary care pediatrician: ____

Name of specialists, nurses, therapists, and/or specialty clinics that regularly see your child:

Name | Phone Number

____

____

Part 4: Medical Insurance Information

Does your child have medical insurance? Medicaid __________ Private __________

If private, what is the name of your insurance provider? ____

Does your child receive any disability payments? Yes __________ No __________

Part 5: Family Information

Please list all family members who live in the same household with the applicant. **Only immediate household members are eligible to go on Bert's Big Adventure:**

Name	Relationship	Age	Birth Date (M/D/YY)	T-Shirt Size

Besides the applicant, are there any other family members residing in the same household as the child with an illness or disability? Yes _____ No _____ If yes, please explain: ____________________________________

____

____

Part 6: Past Disney Trip Information

Has your child ever visited: Walt Disney World? Yes _____ No _____ If yes, what year? ________

Disneyland? Yes _____ No _____ If yes, what year? ________

Please list all family members who have visited Walt Disney World and/or Disneyland: ___________________

____

Is your child on any other list for a trip to Walt Disney World or anywhere else? Yes ________ No ________

If yes, what list and for how long have they been on the list? _______________________________________

Has your child ever received a trip from any other organization? Yes ________ No ________

If yes, what trip(s) has your child received? ____

Part 7: Specific Trip Information - IF your child were accepted…

Would you be able to attend an informational meeting about the trip in early January 2011? Yes ___ No ___

Would your family be able to travel in February 2011 (date pending)? Yes _____ No _____

Would a trip to Walt Disney World be possible without the help of Bert's Big Adventure? Yes _____ No _____

Have you submitted an application to Bert's Big Adventure before? Yes _____ No _____ Year? __________

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Part 8: Release

I hereby certify that the information I have provided in this application is true, correct and complete. I hereby authorize B & S Foundation, Inc., also known as Bert's Big Adventure, or anyone acting on their behalf, to investigate the statements made in this application, and any references provided herein, and further authorize the release of such information without liability to B & S Foundation, Inc., its affiliates and subsidiaries, and their respective officers, directors, employees, agents, successors, and assigns, or any person acting under their authority. **I HEREBY WAIVE, RELEASE AND DISCHARGE B & S FOUNDATION, INC., ITS AFFILIATES AND SUBSIDIARIES, AND THEIR RESPECTIVE OFFICERS, DIRECTORES, EMPLOYEES, AGENTS, SUCCESSORS, AND ASSIGNS, OR ANY PERSON ACTING UNDER THEIR AUTHORITY (RELEASEES) FROM ANY LIABILITY ARISING FROM THE RELEASE OF SUCH INFORMATION, INCLUDING ANY LIABILITY THAT MAY ARISE FROM A NEGLIGENT ACT OR OMISSION OF RELEASEES.**

____
Signature of Person Completing Application

____
Signature of Parent or Legal Guardian

____
Print Name of Person Completing Application

____
Print Name of Parent of Legal Guardian

____
Date (MM/DD/YYYY)

____
Date (MM/DD/YYYY)

DON'T FORGET TO:

COMPLETE THE TOP OF THE MEDICAL QUESTIONNAIRE (PAGE 6)
HAVE THE CHILD'S PHYSICIAN COMPLETE THE BOTTOM HALF OF THE MEDICAL QUESTIONNAIRE
HAVE THE PHYSICIAN FAX THE MEDICAL QUESTIONNAIRE TO BERT'S BIG ADVENTURE
FAX # 404-303-0041

PLEASE MAIL COMPLETED ORIGINAL APPLICATION TO:
BERT'S BIG ADVENTURE
APPLICATION DEPT.
PO BOX 420917
ATLANTA, GA 30342-0917

Note: This application will be considered without regard to race, color, religion, national origin, sex, disability or marital status.

BERT'S BIG ADVENTURE MEDICAL QUESTIONNAIRE

TO BE FILLED OUT BY THE CHILD'S PARENT/LEGAL GUARDIAN:

Name of child applying for Bert's Big Adventure: ____

Name of parent/legal guardian: ____

Home Phone: ________________ Cell: ________________ Work Phone: __________________

I CONSENT TO THE RELEASE OF MEDICAL INFORMATION TO BERT'S BIG ADVENTURE, UNDERSTANDING THAT BERT'S BIG ADVENTURE WILL RESPECT THE CONFIDENTIAL NATURE OF THE INFORMATION GIVEN BY MY CHILD'S PHYSICIAN, ____________________.
Physician's Name

____
Signature of Parent/Legal Guardian

TO BE FILLED OUT BY THE CHILD'S PHYSICIAN:

What is Bert's Big Adventure? Bert's Big Adventure is a registered tax-exempt 501(c)(3) non-profit organization that takes children who are chronically or terminally ill to Walt Disney World for 5 days with their families. Applicants must be between the ages of 5 and 12, live in The Bert Show listening area (99.7 FM) and has never been to Walt Disney World.

PHYSICIAN: Your patient has applied for this trip. Please answer the following questions and fax this form to Bert's Big Adventure. **FAX # 404-303-0041**

1. What is this child's primary diagnosis? ____

2. This is a: serious chronic illness __________ terminal illness __________ birth defect _________

impairment due to an injury or accident ________ Other (specify) ____________________________

3. To the best of your knowledge, have they received any other special trips? Yes _____ No ______

4. Is it safe for this child to participate in a five-day trip to Walt Disney World? Yes _____ No ______

5. Is it likely this child will be able to comprehend and enjoy this trip? Yes _____ No ______

6. Will a trip in February 2011 (dates pending) interfere with medical treatment? Yes ____ No ______

7. Is this child able to travel by airplane? Yes _____ No ______

8. Please indicate any additional concerns or restrictions on a separate sheet of paper.

________________________________ ________________________
Signature of Physician Date

PLEASE FAX TO BERT'S BIG ADVENTURE
404-303-0041