

# Memories of Love Wish Request

4932 Sunbeam Road, Suite 200 Jacksonville, FL 32257 Ph (904)596-2789 Fax (904)636-7780



For Office Use Only

Today's Date: \_\_\_\_\_

Wish trip start date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Alternate Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

## 1. Family Information

Wish Recipient: \_\_\_\_\_  
Last Name First Name  
Sex: \_\_\_\_\_ Age: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Caregiver: \_\_\_\_\_  
Last Name First Name

Address: \_\_\_\_\_

City, State, ZIP: \_\_\_\_\_

Family e-mail address: \_\_\_\_\_

Phone #: \_\_\_\_\_ Cell Phone #: \_\_\_\_\_

*Your entire immediate family can go on the wish trip with you. This includes children (for whom you have legal custody) through age 16.*

Last Name	First Name	Age	Sex	DOB	Relationship
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

## 2. Emergency Contact (Family or close friend to contact while family is in Orlando):

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Cell/pager: \_\_\_\_\_ Home Ph: \_\_\_\_\_

## 3. Referral

Please tell us how you heard about us: Internet, Magazine name, Doctor's office name or friend, etc.

## 4. Wheelchair Acknowledgement

**Memories of Love** neither provides nor has access to wheelchair rental. Wheelchairs may be available at the theme parks on a first come first serve basis. I understand that **Memories of Love** does NOT provide wheelchairs.

Wish Recipient Printed Name: \_\_\_\_\_

Wish Recipient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**5. Pet Policy**

Pets are not allowed on the wish trip provided by **Memories of Love**, if you do bring your pet(s) on a **Memories of Love** wish trip, you will forfeit your hotel accommodations.

Wish Recipient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**6. Ticket Pickup Dates**

The wish trip consists of 2 days at Universal Studios/ Islands of Adventure and 1 day at Sea World. At the Universal parks, you will get one pass good for 2 days. Please indicate the date you will be picking up each park's tickets. You must pick up the tickets on the days you have indicated to assure availability.

Universal Studios Pick Up Date: \_\_\_\_\_ Alternate Dates: \_\_\_\_\_

Sea World Pick Up Date: \_\_\_\_\_

**7. Please check any special needs that apply for your hotel accommodations:**

- \_\_\_\_\_ Refrigeration in room for medications
- \_\_\_\_\_ Wheelchair accessible room
- \_\_\_\_\_ Rollaway bed
- \_\_\_\_\_ Wheelchair accessible room with roll in shower
- \_\_\_\_\_ Non Smoking room

**8. A \$200 travel expense check is available to the wish recipient.**

For check cashing convenience, the check can be written to someone other than the wish recipient.

Whose name should appear on the check? \_\_\_\_\_

**9. Agreement between Memories of Love, Wish Recipient and/or Caregiver.**

I/we hereby expressly acknowledge that I/we have requested that I/we be allowed to participate in a wish being granted to the named wish recipient by **Memories of Love**, a nonprofit organization ("Memories of Love").

**Wish Recipient's Name:** \_\_\_\_\_ **Caregiver's Name:** \_\_\_\_\_

I/we further agree to hold harmless and to release **Memories of Love** and its Releasee from and against any and all claims and causes of action of every kind arising from any and all physical or emotional injuries and/or damages which may happen to me/us, or damage to or theft of our personal belongings, jewelry or other personal property which may occur while staying at, or traveling to or from the accommodations arranged by **Memories of Love**. At no time will any children with me/us be left unattended or unsupervised by an adult throughout our entire stay at the accommodations arranged by **Memories of Love**. In addition I/we acknowledge that I/we am/are guests of **Memories of Love**, and are responsible for any damages to or loss of property at the accommodations arranged by **Memories of Love** caused by me/us or by my/our children.

Wish Recipient Initials \_\_\_\_\_ Caregiver Initials \_\_\_\_\_

By my/our signature(s) set forth below, and in consideration of **Memories of Love** granting said wish, I/we hereby voluntarily, unconditionally, fully and completely release **Memories of Love** and all of its affiliates, participating hospice / hospital organizations / medical care providers (including the authorizing physician named below), agents, officers, directors, servants and employees (the "Releasees") from any liability whatsoever in connection with the preparation, execution and fulfillment of said wish, on behalf of ourselves, the above named wish recipient and all other participants. The scope of this release shall include, but not be limited to, damages or losses or injuries encountered in connection with transportation, food, lodging, medical concerns (physical and emotional), entertainment, photographs and physical injury of any kind.

Wish Recipient Initials \_\_\_\_\_ Caregiver Initials \_\_\_\_\_

I am aware that only wish participants whose names are listed on this form may stay at the accommodations arranged by **Memories of Love** and utilizes services and special offerings. I/we expressly acknowledge and agree that this Liability Release applies to any and all stays or visits granted by **Memories of Love** regardless of when the stay or visit occurs or the duration of the stay or visit.

Wish Recipient Initials \_\_\_\_\_ Caregiver Initials \_\_\_\_\_

With respect to the physical and emotional effects of granting the wish of the above named wish recipient, I/we hereby acknowledge that I/we will consult with and obtain the written authorization of \_\_\_\_\_, MD (Please Print Doctor's Name) who is the above named wish recipient's physician, to allow the above named wish recipient to participate in the wish, and will follow the advice of said physician in connection therewith.

Wish Recipient Initials \_\_\_\_\_

Caregiver Initials \_\_\_\_\_

I/we further agree that in the case of emergencies wherein the wish recipient becomes ill and must be hospitalized or flown home, whether via commercial airline, private or air ambulance, I/we assume all legal and monetary responsibilities. In the event the wish recipient passes away during his/her vacation granted by **Memories of Love**, the family of wish recipient will make necessary arrangements with a funeral home and for travel to get the wish recipient and the family home.

Wish Recipient Initials \_\_\_\_\_

Caregiver Initials \_\_\_\_\_

By my/our signature(s) set forth below, I/we further authorize **Memories of Love** and any of its Releasees to photograph, film and/or electronically record interviews with me/us in such a manner as they choose. I/we further authorize **Memories of Love**, its Releasees or any person or organization participating in the taking of said photographs, films and /or electronically recorded interviews to distribute now or at any time in the future, all of said photographs, films and/or electronically recorded interviews to anyone including the general public, magazines, newspapers, television and radio stations, and/or any other organization or person that customarily presents information or news to the general public. I/we further authorize **Memories of Love** and its Releasees to disclose to the general public, as well as to television and radio stations, newspapers or magazines, or any other form of news or public media, now or at any time in the future, my/our name(s) and the details of the wish in which I am/we are participating.

Wish Recipient Initials \_\_\_\_\_

I/we agree(s) that, upon the sole and exclusive election of **Memories of Love** and/or any of its Releasees, any claim, dispute, or controversy (whether in contract, tort, or otherwise) arising from or relating to this Release, including the validity or enforceability of this arbitration clause or any part thereof or the entire contract, shall be resolved by binding arbitration under the Rules of the American Arbitration Association in Jacksonville, Florida. The Arbitration Panel will consist of three (3) members. The parties exclusively select the application of Florida substantive law without resort to Florida's Conflict of Law Rules to resolve legal issues that may arise in the course of such arbitration. Should any such controversy arising from or related to this Release be litigated rather than arbitrated, the parties select as the sole and exclusive venue for any such litigation the state and federal courts in Jacksonville, Florida.

Wish Recipient Initials \_\_\_\_\_

I/we have not been promised by any agent, director, officer, servant, or employee or **Memories of Love**, nor has any person associated with said organization given any advice or counsel with respect to the advisability and risk associated with said wish. In that regard, I/we are relying solely upon the advice and information supplied to me/us by **Memories of Love and Releasees are** acting and have acted solely at my/our request and in accordance with and pursuant to my/our instructions.

Wish Recipient Initials \_\_\_\_\_

The person whose signature appears below has unconditional authority to execute this document on behalf of **Memories of Love**.

I/we hereby warrant that I/we have read the foregoing Release and executed it freely and voluntarily.

Wish Recipient: \_\_\_\_\_

Date: \_\_\_\_\_

Caregiver: \_\_\_\_\_

Date: \_\_\_\_\_

Parent Signature of all minor children included in this Wish Trip:

\_\_\_\_\_

Date: \_\_\_\_\_





# MEDICAL AUTHORIZATION

WISH ADULT \_\_\_\_\_

**TO BE SIGNED AND DATED  
BY WISH RECIPIENT'S  
PRIMARY PHYSICIAN**

ADULT DIAGNOSIS \_\_\_\_\_



Memories of Love  
FOUNDATION  
4932 Sunbeam Road  
Jacksonville, FL 32257

As the primary care physician for \_\_\_\_\_,  
(PLEASE PRINT WISH ADULT'S NAME)

I \_\_\_\_\_, M.D. am familiar with the physical condition of the above named adult and am of the opinion that the condition of the above named adult has a life-threatening and/or terminal illness. I have explained to the above named patient and/or spouse/guardian the medical condition of the above named patient. I have discussed with the patient and/or spouse/guardian the risks involved (both physically and mentally) by participation by the above named patient in fulfillment of the wish (as it was explained to me and hereinafter described). I have instructed them as to who to call in the event medical assistance is needed and how to handle medical emergencies.

## DESCRIPTION OF WISH

Travel to Central Florida to spend up to six days/five nights at a Holiday Inn and visit theme parks: Universal Studios / Islands of Adventures and SeaWorld.

Restrictions: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
PHYSICIAN'S SIGNATURE  
*(Nurse or office staff cannot sign this  
form on behalf of doctor)*

\_\_\_\_\_  
SIGNATURE OF WITNESS

\_\_\_\_\_  
PRINT PHYSICIAN'S NAME

\_\_\_\_\_  
DATE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PHYSICIAN'S OFFICE NAME & ADDRESS

\_\_\_\_\_  
PHYSICIAN'S OFFICE PHONE

Thank you for taking the time to complete this form for your patient.

Doctor, is this your first introduction to Memories of Love? yes \_\_\_\_\_ no \_\_\_\_\_  
If yes, how did you learn about us? \_\_\_\_\_ patient? \_\_\_\_\_ colleague? \_\_\_\_\_ other?