



Website: www.12oaksfoundation.org

Email: info@12oaksfoundation.org

668 Indian Path Road, Grayslake Illinois 60030

Phone 847-508-1168

Fax 847-231-0991

Matt Hupp was a kid whose enthusiasm and fervor for life was evident in his love of sports. The life lessons Matt learned on the field helped him in his fight with cancer. The mission of the 12 Oaks Foundation is to provide a resource that will help defray the cost of sports and other community programs for children in families suffering from the financial hardships associated with ongoing cancer treatment. Working with local organizations, the 12 Oaks Foundation will provide grants to families in need so their kids won't have to miss some of the best parts of childhood. We saw what extracurricular activities gave to Matt. No child should have to miss the opportunity to develop a strong character through teamwork, competition, and problem-solving that comes with these activities. So please take a few minutes to introduce yourselves and tell us what your extracurricular activity means to you and your child.

Parents Name/ Information

Name: _____

Address: _____ City, State, Zip: _____

Phone number: Home (_____) _____ Work _____

Cell (_____) _____ Email Address: _____

Gender: ___Male ___Female

Patients Name

Child's Name: _____ Date of Birth: _____ Grade: _____

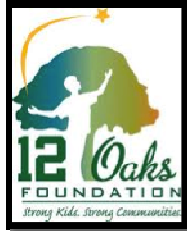
CONSENT TO EXCHANGE INFORMATION

I understand that additional information may be required to properly verify grant eligibility. By signing this form, I am permitting the **12 Oaks Foundation** to contact the above organization/individual using the information provided on the form. I attest that I have filled out this form completely and accurately to the best of my knowledge. I assert that receipt of a grant will aid in easing financial difficulties which would otherwise exist if expenses related to my child's activity were paid out of family funds.

PRINTED NAME OF PARENT/GUARDIAN

SIGNATURE

Date: _____



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***Please Note: This section to be completed by patient's doctor or social worker. All signatures must be original.**

Patient Diagnosis: _____ Date of Diagnosis: _____

Provider Name: _____ Hospital/Clinic: _____

Address: _____ City, State, Zip: _____

Phone: (____) _____ Fax: (__) _____

Physician/Social Worker Signature: _____

Date: _____

