The Miracle Story **Form**

Child's Name:

Child's Age:

Child's Birthday:

Parent(s) Names:

Contact Info. (Check your communication preference(s)):

Current Mailing Address:

Phone #: Email:

Social Media

Facebook:

CaringBridge:

Siblings

Name: Age:

Name: Age:

Name: Age:

Describe your Miracle Story (significant dates, diagnosis, treatment process, limitations, health status, facilities & services utilized):

Please return forms or direct questions to:
Piedmont Columbus Regional Foundation
707 Center Street, Suite 100
Columbus, Georgia, 31901
Fax: 706.660.6219
706.660.6115

THE CHILDREN'S HOSPITAL

07605-0518

The Miracle Story Form

When did you begin your relationship with our CMN Hospital?

Have you been treated at any other CMN Hospital(s)? If so, please list:

How may we disclose your story? (Check all that apply)

- Attend sponsored events to give testimonials
- Allow us to share story at sponsored events
- Utilize story as marketing collateral for print media
- Publish story and testimonials on website and social media

Help us get to know your Miracle Child!

Pets?

Favorite food?

Special talent?

Favorite book?

Role model or hero?

Favorite things to do?

Is there anything else you would like to share with us?

BY SIGNING THIS CONSENT: I, , do here by authorize Columbus Regional Health Foundation to disclose the above information (excluding child's birthday and all contact information) for marketing, fundraising, and media use. I acknowledge that I have read or had this form read to me, that I fully understand it's content, and that I have been given ample opportunity to ask questions and that these questions were answered satisfactorily. All blanks or statements requiring completion were filled in and all statements I do not approve stricken before I signed this form.

Signature of patient or authorize persons | Date

Print Name | Date

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