

Today's Date: _____



Application for Visitation and Donations

*****HOLIDAY VISITS ARE VISITS FROM NOVEMBER 1 — JANUARY 5
Visitation slots are limited and are filled on a first-come, first-served basis or
based on prior visitation preference*****

**ALL VISITS AND DONATIONS MUST BE COORDINATED THROUGH THE CHILD LIFE DEPARTMENT
2 WEEKS NOTICE IS REQUIRED FOR ALL VISITS**

Name of Group/Performance: _____

Contact Person: _____

Phone Numbers: Home: _____ Work: _____ Cell: _____

Address _____

City, State, Zip: _____

E-mail: _____

Description of presentation: _____

Number of persons in your group (must be less than 5, unless approved by SCH): _____

Please note, if anyone in your group is sick (including a cough or cold) they will not be admitted onto the Children's Hospital units due to the safety of our patients.

Target audience age group: _____

Facilities and/or equipment needed: _____

Is this your first visit to Sunrise Children's Hospital? Yes No

If no, when was your last visit? _____

Are you planning on handing out gifts? Yes No

If yes, please provide a detailed description of what you will be bringing.

Today's Date: _____

Proposed date of visit: _____

Proposed time of visit (Please note all visits are limited to 1 hour or less): _____

Is media coverage being sought? Yes No

If yes, please note that ALL media MUST be handled through the Sunrise Children's Hospital marketing department at (702) 731-8288.

As a representative of the above name organization, I have read the guidelines for entertainers or groups visiting Sunrise Children's Hospital and agree to adhere to the following requirements:

Please Initial:

____ I understand that all community visitors must be 14 years old.

____ I understand that I must submit this application at least 2 weeks prior to visit.

____ I understand that entertainment groups must contain less than 5 people.

____ I understand that due to privacy laws, I may not ask patients or families any questions regarding their diagnosis, age, length of stay, or plan for going home.

____ I understand that any presentations or gifts must be politically and religiously neutral.

____ I understand that photographs of patients and families may not be taken by visiting groups or individuals.

____ I understand that if I do not arrive at my scheduled time the visit will be rescheduled for another day.

Print name: _____

Signature: _____

Date: _____

Please note that room-to-room visit requests are not always available due to the illness of each individual patient. For additional questions, please contact Child Life at (702) 731-8961.

**Please return this form at least two weeks prior to proposed visit date by email to
Kimberly.Grettum@hcahealthcare.com**