



Parking Pass Program Application for 18+

We seek to help patients over the age of 18 by providing parking passes and referring to other organizations when we see a need that can be met.

Part 1: To be completed by Patient. Please Print Clearly.

Patient Name: _____

Patient Email: _____

Date of Birth: _____ Gender: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Caringbridge/social media pages (we love to follow your journey):

Parent/Legal Guardian/Emergency Contact Information

Name: _____

Phone: _____ Email: _____

Name: _____

Phone: _____ Email: _____

Part 2: Patient Needs: To be completed by Patient

_____Parking Relief- We will provide financial assistance for parking at John Hopkins Hospital. This program has no age restrictions.

***Funds are available as they last on an annual basis. This is limited to Maryland residents or those being treated at a Maryland hospital.**

Part 3: Medical Assessment to be completed by Social Worker, Child Life Specialist, Nurse or Physician. Please Print Clearly.

Hospital Name: _____

Healthcare professional name and title: _____

Email Address: _____

Phone Number: _____

Type of Cancer: _____

Date of Diagnosis: _____

Is the patient currently undergoing treatment? _____

If not, last day of treatment: _____

I verify that this patient is in treatment or has been treated:

(Healthcare professional signature & date)

Liability Release and Authorization Disclosure: As a requirement for participation in any Just In Power Kids Inc., program or service the patient must sign this liability release and authorization disclosure. Just In Power Kids, Inc. is a program designed to assist children receiving treatment for cancer and other types of medical issues. Just In Power Kids, Inc. will provide referrals to alternative medicine treatment to aid children during the process and will pay for out of pocket expenses for those treatments. Children receiving funding and any referral based upon this application should consult with their primary care physician before beginning any alternative treatment. An application does not guarantee acceptance by Just In Power Kids, Inc. as program needs are based upon provider availability and funding to aid in treatment.

Liability Release: The undersigned both individually, jointly and on behalf of the child who is eligible to participate in Just In Power Kids, Inc. referral service understand that Just In Power Kids, Inc. referral service makes absolutely no representation or guarantee to the like, quality, kind or type of referral provider. Just In Power Kids, Inc. does not guarantee the effectiveness or quality of any referral The undersigned both individually, jointly and on behalf of the child who is eligible to participate in Just In Power Kids, Inc. programs does hereby agree to release, forever discharge and

hold the Just In Power Kids, Inc., their directors, officers, employees, agents, volunteers, successors and assigns harmless from and against any and all actions, causes of actions, liability, claims and demands for, any damages and claims of any kind whatsoever, whether known or unknown, in connection with or arising from any incident(s) or occurrence(s) during the child's participation or consideration of participation in Just In Power Kids, Inc. programs. Application to this program does not guarantee funding of any kind from Just In Power Kids, Inc.

Authorization regarding publicity: It is understood and agreed that participation in Just In Power Kids, Inc. may result in publicity that in order for Just In Power Kids, Inc. to continue its services, it is helpful to be able to portray patients and families using services in a positive way in brochures, newsletters, websites, and other promotional materials. The undersigned both individually, jointly and on behalf of the patient who is eligible to participate in Just In Power Kids, Inc. authorize Just In Power Kids, Inc. to use the name and image of the patient for publicity and promotional purposes. **I grant**

____ I deny ____ permission for Just In Power Kids , Inc. to use my name and image in Just In Power Kids promotional materials. This Liability Release and Authorization Disclosure contains the entire agreement between the patient and Just In Power Kids, Inc. and that the terms hereof are contractual and not a mere recital. By signing below, the patient acknowledges that they have read, understand and consent to the terms set forth herein.

Patient Printed Name: _____

Patient Signature: _____ **Date:** _____

**Please complete all sections of this form and return
via email or mail:**

Just In Power Kids, Inc.

bethanyjipk@gmail.com

1100 Business Pkwy S Unit 4Westminster, MD 21157

*The next step in the process will be an email or phone call from our Program Director to welcome you and answer any questions you have about our programs and our organization.