

BEAUTY BUS MEDICAL RELEASE FOR NATIONAL BAG OF BEAUTY PROGRAM



Beauty Bus Foundation
2716 Ocean Park Blvd., Suite 1062
Santa Monica, CA 90405
phone 310.392.0900 | fax 310.392.0907
www.beautybus.org

BEAUTY BUS FOUNDATION
MEDICAL RELEASE FORM FOR NATIONAL BAG OF BEAUTY PROGRAM

NOTE: This form may be filled out by any licensed medical professional within the scope of his/her practice.

Medical Professional:

Your patient, _____, has requested a Bag of Beauty from the Beauty Bus Foundation. Beauty Bus Foundation is a Los Angeles based non-profit organization that delivers dignity, hope and respite to chronically or terminally ill men, women and children and their caregivers through beauty and grooming services and pampering products.

Beauty Bus sends complimentary Bags of Beauty filled with pampering products to remind chronically or terminally ill men, women and children around the country and their caregivers to remind them that they deserve to look and feel beautiful. This program is reserved for clients with the following illnesses or conditions, which prevent them from accessing a salon or spa: ALS (Lou Gehrig's Disease), Cancer, Multiple Sclerosis, Muscular Dystrophy, Parkinson's Disease, Spinal Cord Injuries, Stroke and other select Neuromuscular and Motor Neuron Diseases.

I, _____ (Print Name of Medical Provider),
represent that:

Patient Name: _____

has the following disease or condition: ALS (Lou Gehrig's Disease)
 Cancer Multiple Sclerosis Muscular Dystrophy
 Parkinson's Disease Spinal Cord Injuries Stroke
 Other select Neuromuscular and Motor Neuron Diseases
(Please specify) _____

BEAUTY BUS MEDICAL RELEASE FOR NATIONAL BAG OF BEAUTY PROGRAM

- **and that his/her condition prevents him/her from being able to access a salon or spa.**
- **I also authorize and release _____(patient name) to receive a Bag of Beauty from Beauty Bus Foundation.**

Does applicant have any allergies to beauty products or any allergies that might be affected by products in the Bag of Beauty? ____ Yes ____ No

If Yes, please explain: _____

Is there anything else that we should be aware of that might affect Beauty Bus's ability to provide a Bag of Beauty? _____

Print Medical Professional Name: _____

Medical Professional License Number: _____

State of Licensing: _____

Medical Professional Signature: _____

Phone: _____

Date: _____

Please return completed release form to Beauty Bus Foundation

via one of the following:

Mail: 2716 Ocean Park Blvd., Suite 1062

Santa Monica, CA 90405

Fax: 310-392-0907

Email: bagsofbeauty@beautybus.org