

Child Life Special Events Application

Program Name:

Address:

City:

State:

Zip:

Contact Person:

Phone Number:

Fax Number:

Email Address:

Have you done a special event for Miller Children's Hospital in the past? Yes No

If yes, who was your contact person?

Number of people in group (8-10 people)

Age range of group (16 & older)

Event Description:

[give box with max 2000 characters]

Length of Program: (30-45 minutes)

Set-up time required? Yes No

How much set-up time?

Breakdown Time Required? Yes No

Arrive in costume?

Are breaks out of costume required?

Other places you have performed, contact person at each site, and telephone number

[box with 2000 character max]

Plan to bring gifts? Yes No

If yes, what type of items (minimum of 200 items) [Box with 2000 character max]

Equipment/Materials Requests [max 2000 characters]

Parking Needs car bus van

Number of vehicles

Light Needs

Sound Needs

Space Needs

Preferred Date

Alternate Date

Arrival Time

Start Time