

Special Visitor Application
Request for Special Visit / Event
(Child Life Services)

Your organization's request is evaluated by the child life staff based upon our patient's needs. Child Life staff will notify your organization's contact person with the status of your application. We greatly appreciate your interest.

Name of group or individual: _____

Address: (street) _____

(city, zip code) _____

Contact person: _____ Number in Group (total of 12 or less): _____

Telephone Number: _____ Best time to contact: _____

List top three choices for date and time of visit: (please avoid change of shift times 3:00 pm and 7:00 pm).

Description of activity or donation. Please be specific:

How will the patients benefit from your visit or donation?

Note: Please remember to notify the child life staff in advance if any items, gifts, or treats that will be given to patients or families, or if photos are requested.

Sign and return this form indicating your group has read and agrees to follow all special visitor guidelines. Incomplete applications will not be considered for visits.

Signature (*Group Leader/Contact Person*) _____ Date _____

Print Name: _____

Please mail this application to:

Pediatric Child Life Specialist
St. John's Children's Hospital
800 E. Carpenter
Springfield, IL 62769

To be completed by child life services:

Date of visit: _____ Time of Visit: _____

Application received: _____ Visit/Donation: Accepted _____ Declined _____

Visitor notified: _____