Event ID: 603 Event Name: **Race for Every Child**

___I would like to make a general donation to the event
___I would like to make a donation to a participant

*Participant Name:*_____
___I would like to make a donation to a team

*Team Name:*_____

Donate Now

Thank you for downloading this form from our website to send in your gift to Children's National Health System. Please complete, enclose both your payment and this form, and send to:

Race for Every Child
Children's Hospital Foundation
801 Roeder Road, Suite 300
Silver Spring, MD 20910

By supporting Children's National Health System you are helping kids grow up stronger. Your support will expand access, improve care, and help find cures for childhood diseases. If you have any questions about making a donation, please contact the Foundation office (301) 565-8500 and ask to speak to a member of our gift processing team.

Make your gift:

Selected Gift Amount:
___$25 ___$50 ___$100 ___$250 ___$500 ____Other (indicate amount: $_____)

Donor Information

Title: _____
First Name: _____
Last Name: _____
Company Name: _____
Address 1:_____
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City:_____
State: _____ Zip Code: _____
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Home Phone:_____
Date of Birth*: _____

Payment Type

__ Check (payable to Children's Hospital Foundation)
__Credit Card (indicate type):
__Visa __American Express __Discover __Mastercard
Card Number:_____
CSC Number:_____Exp.Date:_____
Name on card:_____
Signature *(must be hand-signed in order to process payment)*:
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Donor Information will be used as Billing Information, if you are making your gift with a Credit Card

____One time or ____Recurring (# of months____)

**Why do we ask for this? - As a policy, the Children's Hospital Foundation works to limit communications to anyone under 18 years of age. Providing this information will permit us to better communicate with you, while respecting the privacy of our donors and their families.*