

# 2025-2026 Grant Application



## STUDENT INFORMATION

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Street address: \_\_\_\_\_

City / State / ZIP: \_\_\_\_\_

## PARENT OR LEGAL GUARDIAN INFORMATION

Name: \_\_\_\_\_ E-mail address: \_\_\_\_\_

Address: \_\_\_\_\_

Phone number: \_\_\_\_\_ Relationship to student: \_\_\_\_\_

## MEDICAL INFORMATION

Diagnosis (if applicable): \_\_\_\_\_

Name and professional title for person who can confirm student's needs/diagnosis:

\_\_\_\_\_

**SCHOOL INFORMATION** Student's current school \_\_\_\_\_

Student's current age and grade \_\_\_\_\_ Will student attend same school next year? \_\_\_\_\_

If not, what school will the student attend? \_\_\_\_\_

Name / contact info for principal / head of school: \_\_\_\_\_

## STUDENT NEEDS

What does the student need and how would meeting this need impact his or her quality of life in school?

\_\_\_\_\_

\_\_\_\_\_

Grant money requested (approximation): \_\_\_\_\_

Would you accept a partial grant if full request can't be awarded? \_\_\_\_\_

Signature affirming the above is complete and accurate: \_\_\_\_\_

Today's date: \_\_\_\_\_

**Questions?** Email [hello@calliegoldenfoundation.org](mailto:hello@calliegoldenfoundation.org)

**Disclaimers:** Additional information may be needed. Funds will be distributed to the school or company that provides what the child needs. Money will never be distributed directly to the applicant or student. Photos of the child can be used for the Callie Golden Foundation website and other promotional material unless the parent or guardian specifically asks them not to be. Award of a grant doesn't guarantee admission to any particular school. By submitting this application, you agree to allow us to contact you and any other professional, school or company involved with the child's care/grant request. Grants based on available funds. Student must be a resident of or receive educational services in Guilford County. Students must range in age from birth to 18 years.

## Authorization to Communicate with Outside Agencies/Individuals

I, \_\_\_\_\_, voluntarily give the Callie Golden Foundation permission to contact the agencies and/or individuals listed below. I give the Foundation permission to ask for and receive information from these agencies/individuals about my child's diagnosis and/or health care plan. I understand the Foundation will seek only information that is pertinent to my grant application and will not share this information with any other entity.

This authorization will expire one year from today's date as printed below.

Student's name: \_\_\_\_\_

Parent or legal guardian (representative): \_\_\_\_\_

Signature: \_\_\_\_\_

Today's date: \_\_\_\_\_

### Agencies / individuals that the Callie Golden Foundation can contact:

Agency / individual's name: \_\_\_\_\_ Phone: \_\_\_\_\_

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Agency / individual's name: \_\_\_\_\_ Phone: \_\_\_\_\_

Agency / individual's name: \_\_\_\_\_ Phone: \_\_\_\_\_



**PLEASE MAIL COMPLETED FORM TO:**

Callie Golden Foundation  
P.O. Box 6226  
High Point, NC 27262  
[www.calliegoldenfoundation.org](http://www.calliegoldenfoundation.org)