



Children's Health



Donor Name: _____

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Enclosed is my gift to the Lucile Packard Children's Fund:

If you wish to designate your gift to an area other than the Children's Fund, please indicate here:

☐ One-time Gift: ☐ \$1,000 ☐ \$750 ☐ \$500 ☐ \$250 ☐ \$100 ☐ Other: _____

☐ Monthly Gift*: _____

*By signing below, you authorize LPFCH to automatically process your gift as a secure credit card transaction during the first week of each month (please include account information below). We will continue to process your monthly gifts until you ask to discontinue your participation, which you can do at any time by calling [650-461-9980](tel:650-461-9980). I HAVE READ, UNDERSTOOD, AND ACCEPT THIS AGREEMENT:

Signature: _____

I am making my gift by:

☐ Check (payable to Lucile Packard Foundation for Children's Health)

☐ Credit card:

Credit Card Information:

Account Number: _____ Exp. Date: _____

Authorized Signature: _____

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Optional This contribution is:

In memory of: _____

In honor of: _____

Please send notification of my contribution to: (no amount is mentioned)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Please complete and mail with your check or credit card information to:
Lucile Packard Foundation for Children's Health, Attn: Advancement Services
P.O. Box 847105, Los Angeles, CA 90084-7105