APPLICATION FORM

Child's Information

Full Name:		Preferred Name:	
Nature of illness or disability:			
Sex (please tick): Male ☐ Female☐		Date of Birth:	
Height:	Weight:	Clothing Size:	Shoe Size:

Does your child speak and understand English?	Please tick	Yes ☐	No ☐
Does your child have a passport?	Please tick	Yes ☐	No ☐
Has your child been on an overseas trip before?	Please tick	Yes ☐	No ☐
If yes, please provide details, if Australia or America, please be specific of areas visited and activities undertaken:			

Parent or Guardian Information

Title: Mr/Mrs/Ms/Miss	Surname:	First Name(s):
Are you a Parent ☐ or Guardian ☐ (please tick)		
Street Number & Name:		
Suburb:		
Town/City		
Postcode		
Email		
Telephone: Home (0)	Business: (0)	Mobile: (02)

Medical Contact Information

GP's Name:		Telephone Number (0)
Address		
Specialist's Name:		Telephone Number (0)
Address		

When was your child last hospitalized?
What was the reason?

Who provided this application form?
Who was your referral?

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General Information (to be completed by Parent of Guardian)		
Does your child require any special assistance? Please tick: Yes ☐ No ☐ *(i.e. Peak flow, Physio, Dressings, Catheters, Night nappies etc)*		
If yes, please specify		
Does your child need or use any of the following:		
Hearing Aids? Yes ☐ No ☐	Artificial Limbs Yes ☐ No ☐	Glasses/Contact Lenses Yes ☐ No☐
Other (Please specify):		
Does your child need or use a wheelchair? Yes ☐ No ☐ Sometimes ☐		
If yes or sometimes, please specify:		
What supplies or equipment will be accompanying your child? ***(e.g. Wheelchair, incontinence pads, bed sheets, dressing pads, nebulizers, physio wedge, etc)***		
Please specify:		

Continence
Is bed-wetting a problem? Please tick Yes ☐ No ☐
Does your child have 'accidents' during the day? Please tick Yes ☐ No ☐
If yes to either of the above, please give details

General Ability Information

Key: 1 – Maximum supervision required, 2 – Supervision required, 3 – Minimal Supervision Required, 4 – Independent (please tick as applicable

Activity	1	2	3	4	N/A	Comments
Medications						
Personal Hygiene/Grooming						
Bathing/Showering						
Toileting						
Dressing						
Meals						
Communication						
Mobility (Indoors/Outdoors)						
Transfers (Bed/Chair/Toilet/Bus						

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Please describe your child's temperament *(Outgoing, reserved, bossy, shy, etc)*			
Does your child require any special monitoring?	Please tick	Yes ☐	No ☐
(If yes, please specify)			
Does your child have any special sleeping patterns or needs?	Please tick	Yes ☐	No ☐
(If yes, please specify)			
Is there any other information that will assist us in catering for your child?			
Can you please indicate how you may be able to help us fundraising?			
Do you have a Relief Care Tax invoice from your Local Health Authority?	Please tick	Yes ☐	No ☐
Are you affiliated with any Iwi, Church or Temples?	Please tick	Yes ☐	No ☐
(if yes, please specify)			

Consents

I, ________________________________, parent/guardian of ______________________________,hereby give KoruCare (Auckland) my permission to use any photographs, film or video taken by them or their sponsors of

____________________ on their Gold Coast/California Adventure trips for the specific purpose of promoting, advertising or displaying the Trust's activities.

Signed Print Name Date

I, ________________________________, parent/guardian of ______________________________,hereby give KoruCare (Auckland) my permission for them to contact my child's school to discuss any relevant aspects with regard to his/her participation in a KoruCare trip.

Name of School _________________________________Telephone number (0____)____________________

Teacher's Name _________________________________ Principal's Name ______________________________

Signed Print Name Date

I, ________________________________, parent/guardian of ______________________________, understand that should my child be withdrawn from a trip for any other reason than a medical or family emergency, any expenses incurred by KoruCare relating to my child may be passed on to me.

Signed Print Name Date

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Consent to Treatment

I, _________________________________, parent/guardian of _______________________________, hereby consent

to the medical/surgical treatment of _______________________________. I acknowledge that my child has been given my full permission to undertake a trip to California, America or the Gold Coast, Australia under the care of KoruCare Charitable Trust and understand the nature of the trip. I consent to my child receiving full medical treatment of any kind whilst in America or Australia and the administering of local or other anesthetics for the purpose of such operation/s. I acknowledge that no assurance has been given that the treatment or operation will be performed by any particular surgeon or pediatrician. Should my child not be current with their vaccinations, I give permission in extreme circumstances, for them to be administered (i.e. tetanus). This consent was read over by myself, the signatory, who acknowledges having understood it fully, and signed in the presence of a witness. I acknowledge that whilst every effort will be made to contact me, in an extreme situation that may not always be possible.

Signed __________________________ Print Name _______________________________ Date _____________

Witness Print Name Date

Checklist

Please read and ensure that you have done the following

- Answered all the questions
- Completed and signed all consent forms
- Have presented medical forms to GP or Specialist to complete

Please note that the information you have provided will be used by KoruCare only for the purpose of evaluating your child's suitability for a KoruCare trip and to provide information to assist us to care for your child if he/she is accepted. This information will remain strictly confidential.

If you have any queries or concerns while completing this application, please contact us. Please do not send an incomplete application form, as it will be returned for completion, and delays may preclude eligibility for an upcoming trip.

Post the completed form to:

KoruCare Charitable Trust
P O Box 125-303
St Heliers
Auckland 1740

Declaration

The information I have provided on this form is correct and the medical forms attached have been given to my child's Doctor/Specialist for completion. I understand that if any information on this form is false, my child's application may be revoked. I understand also, that if my child is selected and travels with KoruCare, they are to behave as an ambassador for KoruCare. Any behavior that jeopardizes the success of the trip may result in the child being sent home early (although only in extreme circumstances). I understand also, that my child's eligibility for a KoruCare trip will also be determined on KoruCare attaining full medical/travel insurance.

Signed Print Name Date

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Medical Assessment *(To be completed by GP, Physician, or Pediatrician)*	**STRICTLY CONFIDENTIAL**
Child's Name:	Date of Birth:
History of Illness or Disability	
Medical Diagnosis:	Recent/Present treatment (surgery, chemo, DXR, physio)
Present Concerns or problems	Current Medications (including dosage, frequency, route)
Special Needs or Precautions	
Allergies: Blood Group: Medic Alert Bracelet: Yes ☐ No ☐ (if yes, please specify) Please tick Nebulizer: Oxygen: Litres/min: Continence Devices:	Additional Medications for trip: *(Antibiotics, Analgesia, Antihistamine, Nebulizers)* Urinary Catheter: Partacath/Atrial Line: Special Diet:

Additional Information			
Immunisation History	Please Tick	Up to date ☐	Unknown ☐

Infectious Disease exposure (dates and ages where applicable)

☐ Measles ____________________

☐ Rubella ____________________

☐ Mumps ____________________

☐ Chickenpox ____________________

If this child is or has received chemotherapy, please ensure the most recent Laboratory results accompany the child on the trip.			
Can this child go swimming?	Please tick	Yes ☐	No ☐
Can this child go on rough rollercoaster/motion master type rides?	Please tick	Yes ☐	No ☐

APPLICATION FORM

System Overview

Head and Neck	Cardiovascular
Hx of Head injury? Headaches?	Hx of heart defects? Arrhythmia? Rheumatic fever?
Eyes, Ears, Nose and Throat Vision? Conjunctivitis? Hx of middle ear infection? Nose bleeds? Sore throats/thrush?	**Respiratory** Hx of respiratory distress? Hx of Asthma? Normal peak flow? Frequent Cough
Gastrointestinal Hx of GI defects? Diarrhoea/Constipation? Frequent stomach aches? Normal bowel pattern? Laxative/Enema use?	**Genitourinary** Hx of GU defects? Frequency/Pain/UTI's? Continent? Nocturnal enuresis? Menses?
Skin Rashes? Lesions? Hx of scabies/impetigo?	**Endocrine** Hx of jaundice/anemia? Bruise easily? Diabetic?
Neurologic Hx of seizures? Fainting/dizzy spells? Attention span? Development delay?	**Musculoskeletal** Hx of injuries/deformities? Co-ordination? Strength? Joint pain/ROM?

Other?

Please comment on Child's General Condition and Suitability

Declaration

The information given on this form is correct and I have included any reservations I may have regarding the participation of this child on a trip.

Signed: Date:

Name (please print): Telephone (0) Fax (0)