



KORU CARE TRIP APPLICATION FORM

To be completed by Parent/Guardian

PLEASE PRINT CLEARLY

CHILDS INFORMATION			
Child's Full Name: (As per birth certificate/passport)		Prefers to be called:	
Nature of Illness/Disability:			
Sex:	Male/Female	(please circle)	Date of Birth: Must be aged between 8 & 15
Height:	Weight:	Clothing Size:	Top Bottom
PARENT/GUARDIAN INFORMATION			
Title:	Mr/Mrs/Ms	Surname:	First Name(s)
Are you a parent or guardian? (please circle)			
Street Number & Name:			
Suburb:			
Town/City:			
Telephone Contact	Home:	Business:	Mobile:
EMAIL ADDRESS			
TRAVEL			
Does your child have a Passport?		Yes/No	(please circle)
Has your child been overseas before?		Yes/No	(please circle)
If yes, please give details			
If yes was it with Koru Care/Make A Wish/Jingle Bail or similar			
MEDICAL CONTACT INFORMATION			
GP's Name:		Telephone:	
Address:			
Specialist's Name:		Telephone:	
Address:			
Who provided this application form? Who was your referral?			

GENERAL INFORMATION**To be completed by Parent/Guardian****When was your child last in hospital? For what reason?****Does your child require any special assistance?
i.e. Peak flow, Physio, Dressings, Catheters, Others****YES/NO
(Please circle)****If yes please specify.****Does your child need or use :
Hearing Aids:****YES/NO****Glasses/Contact Lenses:****YES/NO****Does your child need/use a wheelchair?****YES/NO/SOMETIMES
(Please circle)****If yes/sometimes, please state the exact type of assistance
required i.e. can child stand, transfer from chair to toilet
unaided etc.****CONTINENCE****Is bed wetting a problem?****YES/NO****Does your child have 'accidents' during the day?****YES/NO****If YES to either of the above please give details.****What supplies/equipment will be accompanying your child?****(e.g. Wheelchair, incontinence pads, bed sheets, dressing packs, nebulisers, physio wedge)****Please specify:**

GENERAL ABILITY INFORMATION

ACTIVITY	YES/NO	WHAT SPECIAL ASSISTANCE/TREATMENT WOULD YOUR CHILD REQUIRE WHILE AWAY
Medications	YES/NO	
Personal Hygiene/Grooming	YES/NO	
Bathing/Showering	YES/NO	
Toileting	YES/NO	
Dressing	YES/NO	
Meals/Eating	YES/NO	
Communication	YES/NO	
Mobility (i.e. indoors/outdoors)	YES/NO	
Physio	YES/NO	
Transfers (i.e. bed/chair/toilet/bus)	YES/NO	

To ensure your child has a wonderful holiday please tell us a little more about your child, e.g. personality, bed time routine, helpful hints.

Sleeping pattern. Any special needs? e.g. cuddly bed time toy? Does your child sleep walk? YES/NO

Is there any other information that will assist us in caring for your child?
(Please use separate pages if you need more room).

CONSENT FORMS

Iparent/guardian of hereby give Koru Care (CHC) my permission for them to contact my child's school to discuss any relevant aspects with regards to his or her participation on a Koru Care trip.

Name of School:

Phone Number:

Principal's Name:

Signed

Print Name

Date

I (full name of parent/guardian) being the parent of Aged (child's date of birth) consent to full access and release of medical information to the Medical/Nursing Representatives of the Koru Care Christchurch Charitable Trust. I understand that once obtained the information will only be divulged to the Medical Team and carers of the Koru Care Charitable Trust and the Insurance Company.

Doctor

Phone

Outreach Nurse

Phone

Signed

Print Name

Date

Iparent/guardian of agree to Koru Care using any photographs/film of my child for publicity purposes and for fund raising.

Signed

Print Name

Date

Iparent/guardian of agree to accept any considered decision made by the Koru Care escorts in respect of the welfare of my child, including medical care if required. In this respect I authorise the escorts to act on my behalf.

Signed

Print Name

Date

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 can be revoked. I understand also, that if my child is selected and travels with Koru Care, if his or her behaviour should jeopardise the safety and security of the trip, he or she may be sent home.

Signed

Print Name

Date

MEDICAL ASSESSMENT**STRICTLY CONFIDENTIAL****(To be completed by GP, PHYSICIAN, PAEDIATRICIAN)****Childs Name:****Date of Birth:****Blood Group if known:****Height:****Weight:****HISTORY OF ILLNESS/DISABILITY****Medical Diagnosis****Recent/Present Treatment (surgery, chemo, DXR, physio)****Present Concerns/Problems****Allergies: Food/Medication****Current Medications****Drug****Dose****Frequency****Route**

Gastrointestinal Hx of GI defects? Diarrhoea/Constipation? Frequent stomach aches? Normal bowel pattern? Laxative/enema use?	Genitourinary Hx of GU defects? Frequency/pain/UTIs? Continent? Nocturnal enuresis? Menses?
Skin Rashes? Lesions? Hx of scabies/impetigo?	Endocrine Hx of jaundice/anaemia? 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 – INCLUDING PHYSIOLOGICAL/SOCIAL	
PLEASE COMMENT ON CHILD’S GENERAL CONDITION AND SUITABILITY	

This information given on this form is correct and I have included any reservations I may have regarding the participation of this child on the trip.	
Signed	Dated
Name (please print)	Fax
Phone	Email

CHECKLIST

Please ensure you have done the following:

- **Answered all questions**
- **Completed and signed all consent forms**
- **Medical pages 5, 6, & 7 completed by GP/Specialist/Paediatrician**

If possible please include a photo.

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

Submitting an application does not mean that the trip is assured.

Please do not send in an in-complete application form, as it may be returned for completion. If you have any queries or concerns while completing this application, please contact either:

**Chris George
Chairman Koru Care
Air N.Z. Engineering
Christchurch Airport
Ph (03) 3593517 Home
Cell 0275 415 201 or
03 3747440 work**

**or Janetta Skiba
Medical Co-ordinator
Koru Care
Ph (03) 3528006 Home
Cell 021 769956 or 349 0928 work
03 3528 006 (fax)**

**Post To: Koru Care (CHC) Charitable Trust
P O Box 14034
Christchurch Airport**