



APPLICATION FORM

Child's Information			
Full Name:		Preferred Name:	
Nature of illness or disability:			
Sex (please tick): Male <input type="checkbox"/> Female <input type="checkbox"/>		Date of Birth:	
Height:	Weight:	Clothing Size:	Shoe Size:
Does your child speak and understand English?		Please tick	Yes <input type="checkbox"/> No <input type="checkbox"/>
Does your child have a passport?		Please tick	Yes <input type="checkbox"/> No <input type="checkbox"/>
Has your child been on an overseas trip before?		Please tick	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> or Guardian <input type="checkbox"/> (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? <i>(i.e. Peak flow, Physio, Dressings, Catheters, Night nappies etc)</i>		Please tick:	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please specify			
Does your child need or use any of the following:			
Hearing Aids? Yes <input type="checkbox"/> No <input type="checkbox"/>	Artificial Limbs Yes <input type="checkbox"/> No <input type="checkbox"/>	Glasses/Contact Lenses Yes <input type="checkbox"/> No <input type="checkbox"/>	
Other (Please specify):			
Does your child need or use a wheelchair?		Yes <input type="checkbox"/>	No <input type="checkbox"/> Sometimes <input type="checkbox"/>
If yes or sometimes, please specify:			
What supplies or equipment will be accompanying your child? <i>(e.g. Wheelchair, incontinence pads, bed sheets, dressing pads, nebulizers, physio wedge, etc)</i>			
Please specify:			

Contenance			
Is bed-wetting a problem?	Please tick	Yes <input type="checkbox"/>	No <input type="checkbox"/>
Does your child have 'accidents' during the day?	Please tick	Yes <input type="checkbox"/>	No <input type="checkbox"/>
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?

Is your child willing to go on theme park rides (if medically allowed)? Please tick Yes No
I would like my details to go on the group mailing list Please tick Yes No

Consents

I, _____, parent/guardian of _____, hereby give Koru Care NZ 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 Koru Care NZ 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 Koru Care NZ 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 Koru Care 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 Koru Care only for the purpose of evaluating your child's suitability for a Koru Care 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 Koru Care. 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 Koru Care attaining full medical/travel insurance.

Signed	Print Name	Date
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APPLICATION FORM

Medical Assessment		STRICTLY CONFIDENTIAL	
<i>(To be completed by GP, Physician, or Pediatrician)</i>			
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:		Additional Medications for trip: <i>(Antibiotics, Analgesia, Antihistamine, Nebulizers)</i>	
Blood Group:		Urinary Catheter:	
Medic Alert Bracelet: Yes <input type="checkbox"/> No <input type="checkbox"/> (if yes, please specify) Please tick		Partacath/Atrial Line:	
Nebulizer:		Special Diet:	
Oxygen: Litres/min:			
Contenance Devices:			
Additional Information			
Immunisation History		Please Tick Up to date <input type="checkbox"/> Unknown <input type="checkbox"/>	
Infectious Disease exposure (dates and ages where applicable)			
<input type="checkbox"/> Measles <input type="checkbox"/> Rubella <input type="checkbox"/> Mumps <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>
Can this child go on rough rollercoaster/motion master type rides?		Please tick	Yes <input type="checkbox"/> No <input type="checkbox"/>



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System Overview	
Head and Neck Hx of Head injury? Headaches?	Cardiovascular 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)