



IMPORTANT – Please read before proceeding with the Application

1. USA Travel/Entry Requirements

Your child **MUST** be Covid 19 Vaccinated to meet requirements of the USA Border Security.

<https://nz.usembassy.gov/covid-19-information/#travel>

**** As of 12:01 a.m. EDT June 12, 2022, the CDC order requiring all persons aged two and above to show a negative COVID-19 test result or documentation of recovery from COVID-19 before boarding a flight to the United States is rescinded. Starting at 12:01 a.m. EDT on June 12, 2022, the CDC will no longer order air passengers to show a negative COVID-19 test result, or show documentation of recovery from COVID-19, prior to boarding a flight to the United States. **Of note, CDC's Order requiring proof of vaccination for non-U.S. citizen nonimmigrants to travel to the United States is still in effect.***

2. Proof of Covid 19 Vaccinations

This is required as per child for the purpose of obtaining Medical Insurance and **MUST** be provided along with the Application Form.

KORU CARE CHRISTCHURCH 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

PARENT/GUARDIAN INFORMATION

Mother: Surname:

First Name:

Father: Surname:

First Name:

Guardian: Surname

First Name

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

Yes/No (please circle)

COVID 19 proof of vaccination MUST be included with application

Yes/No (please circle)

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? **YES/NO**
i.e. Peak flow, Physio, Dressings, Catheters, Others **(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		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	
Communications	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 bedtime 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.....(childs date of birth) consent to full access and release of medical information to the Medical/Nursing Representative of the Koru Care Charitable Trust. I understand that once obtained the information will not only be divulged to the Medical Team and carers of the Koru Care CharitableTrust and the Insurance Company.

Doctor:..... Phone:.....

Outreach Nurse: Phone:

Signed:.....Print Name

Date:

I.....parent/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 authorize 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 NameDate:

SPECIAL NEEDS OR PRECAUTIONS

Special Diet

Additional Medications for Trip: (Antibiotics, Analgesia, Antihistamine, Nebulisers)

Will your child need:

Nebuliser: YES/NO

Oxygen: YES/NO

PORTACATH/ATRIAL LINE

Urinary Catheter:

Contenance Devices:

ADDITIONAL INFORMATION

Immunisation History? Up to Date/Unknown

Include Tetanus if known

Covid-19 Vaccinated? YES/NO (Please circle)

Infectious Disease Exposure (Dates or Ages where applicable)

Measles

Rubella

Mumps

Chickenpox

Can this child go swimming?

YES/NO (Please circle)

Can this child go on a rollercoaster/simulator type rides?

YES/NO (Please circle)

SYSTEM OVERVIEW

Head & Neck

Hx of Head Injury?

Headaches

Cardivascular

Hx of heart defects?

Arrhythmias?

Rheumatic fever

Eyes, Ears, Nose & Throat

Vision

Conjunctivitis?

Hx of middle ear infections?

Nose Bleeds?

Sore throats/thrush?

Respiratory

Hx of respiratory Distress?

Hx of Asthma

Normal peak flow?

Action Plan

Frequent cough?

MEDICAL ASSESSMENT		STRICTLY CONFIDENTIAL	
(To be completed by GP, PHYSICIAN, PAEDIATRICIAN)			
Child's 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.
- ▶ Provided Proof of Covid 19 Vaccinations

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
Cell 0275 415 201
Email chrisgeorge1@orcon.net.nz

or Janetta Skiba
Medical Co-ordinator
Koru Care
Cell 021 769956
Email janetta.skiba@xtra.co.nz

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