**IMPORTANT – Please read before proceeding with the Application**

1. **Proof of Covid 19 Vaccinations**

   We require this for the purpose of obtaining Medical Insurance and **MUST** be provided along with the Application Form. Thank you.

# 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, nebulizers, 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, bedtime routine, helpful hints.**

**Sleeping pattern. Any special needs? e.g. cuddly bedtime toy? Does your child sleepwalk? 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

**I ……parent/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 ……**

**I ……parent/guardian of ..... agree to Koru Care using any photographs/film of my child for publicity purposes and for fundraising.**

**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 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 |
|---|---|

**(MUST BE COMPLETED BY (NOT PARENT) GP, PHYSICIAN, PAEDIATRICIAN)**

| Child's Name: | Date of Birth |
|---|---|
| | |
| Blood Group if known: | Height: Weight |
| NHI Number: | |

**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 |
|---|---|---|---|
| | | | |

## SPECIAL NEEDS OR PRECAUTIONS

| | |
|---|---|
| Special Diet: | Additional Medications for Trip: (Antibiotics, Analgesia, Antihistamine, Nebulizers) |
| Will your child need:<br><br>Nebulizer: YES/NO Oxygen: YES/NO | |

PORTACATH/ATRIAL LINE

Urinary Catheter:

Continence 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
Whooping Cough
**Please attach vaccination record.**

| | |
|---|---|
| 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
Eyes, Ears, Nose & Throat
Vision
Conjunctivitis?
Hx of middle ear infections?
Nose Bleeds?
Sore throats/thrush

| SYSTEM OVERVIEW | |
|---|---|
| **Cardiovascular**<br>Hx of heart defects?<br>Arrythmias?<br>Rheumatic fever<br>Respiratory<br>Hx of respiratory Distress?<br>Hx of Asthma<br>Normal peak flow?<br>Action Plan<br>Frequent cough? | **Gastrointestinal**<br>Hx of GI defects?<br>Diarrhoea/Constipation?<br>Frequent stomach aches?<br>Normal bowel pattern?<br>Laxative/enema use? |

| | |
|---|---|
| **Genitourinary**<br>Hx of GU defects?<br>Frequency/pain/UTIs?<br>Continent?<br>Nocturnal enuresis?<br>Menses? | **Skin Rashes**<br>Lesions?<br>Hx of scabies/Impetigo? |

| | |
|---|---|
| **Endocrine**<br>Hx of jaundice/anaemia?<br>Bruise easily?<br>Diabetic? | **Neurologic**<br>Hx of seizures?<br>Fainting/dizzy spells?<br>Attention span?<br>Development delay? |

| | |
|---|---|
| **Musculoskeletal**<br>Hx of injuries/deformities?<br>Co-ordination?<br>Strength?<br>Joint pain/ROM? | |

**OTHER – INCLUDING PHYSIOLOGICAL/SOCIAL**

**PLEASE COMMENT ON CHILD'S GENERAL CONDITION & SUITABILITY**

**This information given on this form is correct & 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, & 8 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**