



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	
<p>To ensure your child has a wonderful holiday please tell us a little more about your child, e.g. personality, bedtime routine, helpful hints.</p>		
<p>Sleeping pattern. Any special needs? e.g. cuddly bedtime toy? Does your child sleepwalk? YES/NO</p>		
<p>Is there any other information that will assist us in caring for your child? (Please use separate pages if you need more room)</p>		

CONSENT FORMS

Iparent/guardian ofhereby 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	
<u>(MUST BE COMPLETED BY (NOT PARENT) GP, PHYSICIAN, PAEDIATRICIAN)</u>			
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:

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

Hx of heart defects?
Arrhythmias?
Rheumatic fever
Respiratory
Hx of respiratory Distress?
Hx of Asthma
Normal peak flow?
Action Plan
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/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 & 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

US CUSTOMS & BORDER PROTECTION DECLARATION

Iparent/guardian of

Acknowledge that my son/daughter is travelling to California USA from New Zealand with Koru Care Christchurch Charitable Trust on the trip of a lifetime.

My child's carer for this duration is

Signed Print Name Date

Witnessed by

Signed Print Name Date

Doctor Larry Skiba

MD 1976 Calgary

MRNZCGP 1989

Travelling Doctor Koru Care

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
- ▶ Upon selection, US Customs form to be completed/signed in the presence of a JP

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