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 fund raising.

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: 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? Arrythmias? 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**

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:

Gina Russell
Chairperson Koru Care
Cell 027 6993250
Email korucare@gmail.com

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