The Irish Pilgrimage Trust

Application Form

The Irish Pilgrimage Trust, Kilcuan, Clarinbridge, Galway, H91 W596.
Tel: 091 796622 Fax: 091 796916.
Email: info@irishpilgrimagetrust.com www.irishpilgrimagetrust.com
Charity Registration Number: 20009953 Charity Number 5992

The Blue Section:

This section should be completed by the applicant or by another on their behalf.

PLEASE COMPLETE ALL QUESTIONS IN BLUE SECTION

FOR OFFICE USE	
Supplied by:	
Telephone No:	
2nd Inq	Region

The Red Section:

All applicants must have red section completed by their doctor. If medical section is NOT completed, the form will be returned to you unprocessed.

PLEASE TICK WHICH ONE YOU ARE APPLYING FOR

The closing date for applications:

Easter/Lourdes - 31st October ❑

Summer Friendship Weeks - 31st May ❑

To whom it may concern

Please note that: The information provided by you on this application form will be used by The Irish Pilgrimage Trust to assist in selecting who to take as Guests on the Pilgrimage to Lourdes and on holiday to Cois Cuain and Kilcuan during the Friendship Weeks. You, as the provider of the information are entitled to a copy of the information on request.You, as the provider of the information are entitled to rectify the information if inaccurate or processed unfairly. In addition, where the personal information on this form is not obtained from the Guest personally the Guest is entitled to a copy of this information on request.

THE COMPLETION OF AN APPLICATION FORM DOES NOT GUARANTEE SELECTION

The Irish Pilgrimage Trust welcomes applications from young people with:
A physical disability or illness or a learning disability (aged 11 - 30 years)
A Serious illness up to age 11 accompanied by a parent or guardian (FAMILY GROUPS)
There are places available for young people who have neither a physical disability nor a learning disability but whom the Trust believes would benefit from the experience. Such applications MUST be accompanied by a written recommendation.

All the adults including Group as Leaders, Doctors, Chaplains, Nurses and Carers must undergo vetting and pay their own fare. The Trust is totally dependent on fundraising. Any donation would be gratefully accepted.

PLEASE PRINT

1. SURNAME: _____

2. FORENAME: _____

3. D.O.B.: ____ ____ ____ AGE: ____ ❑ M ❑ F

4. HOME ADDRESS: _____

_____

_____

POST CODE: _____

5. VALID PASSPORT ❑ Y ❑ N

NAME ON PASSPORT _____

EXPIRY DATE OF PASSPORT _____

6. NATIONALITY OF APPLICANT _____

7. FATHER'S NAME: _____

FATHER'S OCCUPATION: _____

MOTHER'S NAME: _____

MOTHER'S OCCUPATION: _____

CONTACT TELEPHONE NUMBER: _____

MOBILE: _____

EMAIL ADDRESS: _____

NUMBER OF SIBLINGS BROTHERS ❑ SISTERS ❑

NAME OF GUARDIAN, only if different from parents

_____

8. WITH WHOM DOES APPLICANT NORMALLY LIVE?

❑ Mother ❑ Father ❑ Both

❑ Guardian ❑ Other(s) ❑ Independently

9. NAME AND ADDRESS FOR CORRESPONDENCE:
(Only if different from Home address)

_____

_____

10. HAS APPLICANT BEEN TO LOURDES BEFORE WITH THE TRUST? ❑ YES ❑ NO

IF "YES", GROUP NUMBER _____ YEAR _____

11. NAME AND ADDRESS OF SCHOOL/CENTRE/WORK:

_____

_____

TEACHER/PRINCIPAL/EMPLOYER NAME:

_____

TELEPHONE NUMBER:

_____

PLEASE INDICATE THE TYPE OF SCHOOL/CENTRE/WORK:

❑ PRIMARY SCHOOL ❑ SECONDARY SCHOOL
❑ SPECIAL CLASS ❑ SPECIAL SCHOOL
❑ TRAINING CENTRE ❑ HOSPITAL
❑ HOME ❑ NONE OF THESE
❑ WORKPLACE

_____

12. IS THE APPLICANT IN RESIDENTIAL CARE?

❑ YES ❑ NO

IF "YES", HOW OFTEN DOES THE APPLICANT GO HOME?

❑ WEEKLY ❑ MONTHLY
❑ HOLIDAYS ❑ NEVER

13. HAS THE APPLICANT EVER BEEN IN RESPITE CARE?

❑ YES ❑ NO

IF "YES", PLEASE GIVE DETAILS

_____

_____

14. NAME OF APPLICANT'S FAMILY DOCTOR:

DR _____

TELEPHONE NUMBER: _____

15. NAME OF APPLICANT'S SPECIALIST:

DR _____

TELEPHONE NUMBER: _____

DOES THE APPLICANT ATTEND HOSPITAL REGULARLY?

❑ YES ❑ NO

HOSPITAL _____

TELEPHONE NUMBER: _____

WHEN WAS APPLICANT LAST IN HOSPITAL

_____

16. NAME OF SOCIALWORKER / PUBLIC HEALTH NURSE

_____

TELEPHONE NUMBER: _____

17. DOES APPLICANT REQUIRE ASSISTANCE WITH:

❑ WALKING ❑ DRESSING
❑ TOILET ❑ WASHING
❑ READING ❑ WRITING
❑ DURING MEALS

(Please indicate level of assistance needed)

_____

_____

18. SPEECH:

IS SPEECH IMPAIRED? ❑ YES ❑ NO

IF "YES",

❑ NO COMMUNICATION ❑ COMMUNICATES BY SIGNS
❑ INDISTINCT SPEECH ❑ LIP READS

19. SIGHT:

❑ NORMAL) ❑ BOTH
❑ PARTIAL SIGHT) IN ❑ LEFT
❑ BLIND) ❑ RIGHT

20. HEARING:

❑ NORMAL) ❑ BOTH
❑ HARD OF HEARING) IN ❑ LEFT
❑ TOTAL DEAFNESS) ❑ RIGHT

21. IS APPLICANT INCONTINENT?

❑ AT NIGHT ❑ DURING DAY

22. DOES APPLICANT USE ANY OF THE FOLLOWING?

❑ HEARING AIDS ❑ WHEELCHAIR
❑ BUGGY ❑ WALKING AIDS
❑ CRUTCHES ❑ CALIPERS
❑ INHALERS ❑ HOIST
❑ BED SIDES ❑ OTHER EQUIPMENT
❑ OXYGEN

PLEASE DETAIL: _____

_____

23. DIET

❑ NORMAL ❑ SLOPPY ❑ LIQUIDISED
❑ NASOGASTRIC ❑ PEG

WHAT FEED IS USED? _____

_____

24. PLEASE LIST ALL MEDICATION BEING TAKEN:

25. PLEASE LIST ANY ALLERGIES:

26. HAS APPLICANT HAD ANY OF THE FOLLOWING

CHICKEN POX INFECTION ❑ YES ❑ NO ❑ DON'T KNOW

MMR VACCINE ❑ YES ❑ NO ❑ DON'T KNOW

TETANUS VACCINE ❑ YES ❑ NO ❑ DON'T KNOW

27. LIST APPLICANT'S HOBBIES / INTERESTS, OR ANY OTHER INFORMATION WHICH MIGHT BE OF HELP:

28. WHICH OF THE FOLLOWING BEST DESCRIBES THE APPLICANT? (*Tick as many as you think*)

❑ NORMAL ❑ NERVOUS ❑ HYPERACTIVE

❑ SHY ❑ HAPPY ❑ EXCITABLE

❑ WITHDRAWN ❑ DISINHIBITED ❑ DEPRESSED

❑ TIRES EASILY ❑ EASILY UPSET ❑ INCLINED TO WANDER

HAS APPLICANT ANY SOCIAL, EMOTIONAL OR BEHAVIOURAL PROBLEMS?

BEHAVIOUR DIFFICULTIES:

WHAT MIGHT CAUSE THESE DIFFICULTIES?

HOW OFTEN WOULD THEY OCCUR?

WHAT WORKS BEST IN RESOLVING THESE DIFFICULTIES?

29. WHY DO YOU THINK THE APPLICANT SHOULD BE CONSIDERED FOR THIS TRIP?

If the applicant has neither a physical disability nor a learning disability, the application MUST be accompanied by a written recommendation outlining why they should be considered.

The Trust is totally dependent on fundraising, any donation would be gratefully received.

ESSENTIAL! TO BE COMPLETED ON BEHALF OF ALL APPLICANTS

I/WE HEREBY APPLY FOR THE ABOVE NAMED TO GO ON PILGRIMAGE TO LOURDES ☐ / KILCUAN ☐ / COIS CUAIN ☐:

WITH THE IRISH PILGRIMAGE TRUST

I/WE GIVE FULL PERMISSION TO THE TRUST'S MEDICAL OFFICER TO MAKE ANY FURTHER NECESSARY INQUIRIES TO ESTABLISH THE APPLICANT'S PRECISE MEDICAL AND CARE REQUIREMENTS ON PILGRIMAGE.

I/WE CONFIRM THAT:

a: the above named applicant will not bring any unprescribed medication or illegal substances.

b: the above named applicant will have a valid Passport and European Health Insurance Card (EHIC) - (Lourdes only).

c: In the event of an emergency, where urgent medical treatment is required, I/we authorise any one of the officials of The Irish Pilgrimage Trust, listed below, to sign on my/our behalf any form of consent required by any medical authorities:

French Translation: En cas d'urgence, où des soins médicaux urgents seraient mecessaries,je/nous autorise/autorisons n'importe lequel des responsables suivants de Irish Pilgrimage Trust ***listés ci-dessous*** *de signer à mon nom un formulaire de consentement exigé par les responsables médicaus.*

Trust Doctor/Nurse/National Co-Ordinator/Chairperson/Group Leader

d: I shall advise the Trust if there is any change in the above named applicant's / my condition or medication between now and the pilgrimage to Lourdes/Kilcuan/Cois Cuain.

I/WE GIVE PERMISSION FOR THE TRUST TO USE PHOTOGRAPHIC MATERIAL IN ALL ITS PUBLICATIONS, INCLUDING HARDCOPY, ELECTRONIC AND INTERNET.

SIGNATURE OF PARENT(S) / LEGAL GUARDIAN(S) /APPLICANT

1. _____ 2. _____ 3. _____

RELATION TO APPLICANT: _____ RELATION TO APPLICANT: _____ APPLICANT: _____

DATE: ____ /____ /____ DATE: ____ /____ /____ DATE: ____ /____ /____

MEDICAL SECTION – TO BE COMPLETED BY DOCTOR

DEAR DOCTOR,
THE FOLLOWING INFORMATION IS REQUIRED TO ESTABLISH THE PRECISE MEDICAL REQUIREMENTS OF YOUR PATIENT. ALL INFORMATION IS CONFIDENTIAL. IF YOU WISH, THIS FORM MAY BE SEALED AND RETURN DIRECTLY TO
THE TRUST MEDICAL OFFICER, THE IRISH PILGRIMAGE TRUST
KILCUAN, CLARINBRIDGE, GALWAY, H91 W596.

THANK YOU FOR YOUR HELP

1. APPLICANT'S SURNAME: _____

2. FORENAME: _____

3. DOB _____

4. GMS/NHS NUMBER _____

5. DIAGNOSIS: _____

_____

_____

6. TO WHAT EXTENT IS APPLICANT AFFECTED:

PHYSICAL DISABILITY

❑ MILD PHYSICAL DISABILITY
❑ MODERATE PHYSICAL DISABILITY
❑ SEVERE PHYSICAL DISABILITY

LEARNING DISABILITY

❑ MILD
❑ MODERATE
❑ SEVERE

7. TICK IF ANY OF THE FOLLOWING IS/ARE PRESENT:

❑ DIABETES
❑ NEURAL TUBE DEFECT (EG. SPINA BIFIDA/HYDROCEPHALUS)
❑ HEART CONDITION
WHAT IS THE NATURE OF LESION?

_____

❑ CYSTIC FIBROSIS
❑ COMPROMISED IMMUNE SYSTEM
❑ ADHD/ADD/ODE
❑ MENTAL HEALTH ISSUES
❑ EPILEPSY / SEIZURES
TYPE:
❑ FEBRILE CONVULSIONS ❑ GRAND MAL
❑ PETIT MAL ❑ PARTIAL SEIZURES
❑ MYOCLONIC ❑ OTHER

WHEN WAS LAST SEIZURE? _____

HOW FREQUENT ARE SEIZURES? _____

8. PLEASE LIST CURRENT MEDICATION/PRINTED COPY:

_____

_____

_____

_____

_____

9. ANY DRUG / ALLERGY SENSITIVITY?

_____

10. HAS PATIENT HAD ANY OF FOLLOWING IN THE PAST YEAR:

❑ CHEMOTHERAPY
❑ IMMUNOSUPPRESSANTS
❑ STEROIDS

PLEASE GIVE DATE OF LAST OCCASION: ____ / ____ / ____

11. IS OXYGEN REQUIRED?

❑ NEVER ❑ SOMETIMES ❑ ALWAYS

12. WHAT SURGERY HAS APPLICANT HAD? AND WHEN?

_____

_____

WHAT SURGERY IS PLANNED? AND WHEN?

_____

_____

13. VACCINATIONS: HAS APPLICANT HAD?

CHICKEN POX INFECTION ❑ YES ❑ NO ❑ DON'T KNOW

MMR VACCINE ❑ YES ❑ NO ❑ DON'T KNOW

DATE OF LAST TETANUS: ____ / ____ / ____

14. ADDITIONAL INFORMATION:
PLEASE LIST ANY FURTHER MEDICAL ADVICE OR INFORMATION WHICH MAY BE USEFUL (E.G. DIET, SHUNTS, SPECIAL AIDS ETC.)

_____

_____

THIS IS VERY IMPORTANT

WHAT IS THE APPLICANT'S WEIGHT? _____

IS THIS EXACT? ❑ **APPROXIMATE?** ❑

16. WOULD YOU LIKE THE TRUST'S MEDICAL OFFICER TO CONTACT YOU REGARDING THIS APPLICATION?

❑ YES ❑ ONLY IF NECESSARY

SIGNED: _____

DATE: _____ / _____ / _____

SURGERY STAMP

THANK YOU!