The Irish Pilgrimage Trust

Charity Number 5992

HOSANNA HOUSE APPLICATION FORM

GROUP No. _____

PLEASE READ CAREFULLY: All information given is strictly confidential. Return your completed form to The Irish Pilgrimage Trust along with your completed Garda Vetting Form (Southern Ireland). Thank you. For more information, please see our website www.irishpilgrimagetrust.com

All participants must complete and sign this Application Form

Please answer all questions

The RED Section (27. Medical Section):
This section **must be** completed by the **Doctor** of the Applicant if the Applicant

A. Is over 70 years of age
B. Has an illness or disability

The completion of an application form does not guarantee a place.

Please return the completed form, as soon as possible, to:

The Irish Pilgrimage Trust
Kilcuan
Clarinbridge
Galway H91 W596

The closing date for applications is -

_____

This years fare is:

€_____

The Pilgrimage is from:

_____ **To** _____

Tel. 091 796622 Fax 091 796916
Email info@irishpilgrimagetrust.com
Website www.irishpilgrimagetrust.com

PLEASE PRINT—CONFIDENTIAL

1. MR___ MRS_____ MS _____ FR ___ SR _____ DR ___
2. SURNAME:

_____

3. FORENAME:

_____

4. DATE OF BIRTH:

_____

5. HOME ADDRESS:

_____

_____

_____

POSTAL CODE:_____

6. HOME TELEPHONE NUMBER:

_____

MOBILE NUMBER:

_____

NAME AND CONTACT NUMBER (ONLY IN CASE OF EMERGENCY):

_____

7. EMAIL ADDRESS:

_____

8. NATIONALITY

_____

9. NAME ON PASSPORT:

_____

COPY OF PASSPORT ENCLOSED: YES ☐ NO ☐

PASSPORT NUMBER:_____

EXPIRY DATE:_____

10. VALID EHIC CARD: YES ☐ NO ☐

EHIC CARD NUMBER_____

EXPIRY DATE:_____

11. HAS APPLICANT BEEN TO LOURDES BEFORE YES ☐ NO ☐

WAS IT WITH THE TRUST? YES ☐ NO ☐

IF "YES", WITH WHAT GROUP?_____WHEN?_____

12. NAME OF APPLICANT'S FAMILY DOCTOR :

DR._____

TELEPHONE NO._____

TOWN:_____

13. NAME OF APPLICANT'S SPECIALIST (IF ANY):

DR._____

TELEPHONE NO._____

WHEN WAS APPLICANT LAST IN HOSPITAL? :_____

_____

DOES APPLICANT ATTEND HOSPITAL REGULARLY? YES ☐ NO ☐

HOSPITAL:_____

TELEPHONE NUMBER:_____

14. ARE YOU IN GOOD PHYSICAL AND MENTAL HEALTH AT PRESENT?

YES ☐ NO ☐

15. HAVE YOU HAD ANY CONDITION IN THE PAST FIVE YEARS WHICH REQUIRED MEDICAL ATTENTION?

YES ☐ NO ☐

IF "YES" PLEASE GIVE DETAILS:_____

_____

_____

_____

16. PLEASE LIST ALL MEDICATION BEING TAKEN / PRINTED COPY

_____

_____

17. DO YOU HAVE ANY OF THE FOLLOWING CONDITIONS?

- ☐ DIABETES TYPE 1 / TYPE 2
- ☐ EPILEPSY
- ☐ HEART DISEASE
- ☐ CANCER
- ☐ RHUMATROID ARTHRITIS
- ☐ INFLAMMATORY BOWEL DISEASE

IF "YES" PLEASE GIVE DETAILS AND LIST OF MEDICATIONS

18. HAVE YOU LIVED IN ENGLAND / SCOTLAND / WALES IN THE PAST 5 YEARS?

YES ☐ NO ☐

19. PLEASE LIST ANY ALLERGIES :

_____

_____

20. PLEASE TICK IF YOU REQUIRE ASSISTANCE WITH :

☐	WALKING	☐	DRESSING
☐	TOILET	☐	MEALS
☐	WASHING	☐	READING
☐	WRITING	☐	DURING NIGHT

21. HAVE YOU ANY SPECIAL REQUIREMENTS ? (PERSONAL AIDS, DIET, APPLIANCES ?)

_____

_____

_____

_____

22. DO YOU USE ANY OF THE FOLLOWING ?

☐	HEARING AIDS	☐	WHEELCHAIR
☐	CRUTCHES	☐	BUGGY
☐	CALIPERS	☐	WALKING AID
☐	OTHER EQUIPMENT		

PLEASE DETAIL : _____

23. ANY OTHER RELEVANT INFORMATION FOR PILGRIMAGE ?

_____

_____

_____

24. This is very important

What is Applicant's Weight: _____

In the event of an emergency, where urgent medical treatment is required, I authorise any one of the official Hosanna House Group Leaders of The Irish Pilgrimage Trust, Kilcuan, Clarinbridge, Galway to sign on my behalf any form of consent required by any medical authority.

25. ESSENTIAL FOR ALL APPLICANTS!

I HEREBY APPLY TO GO ON PILGRIMAGE TO LOURDES WITH THE IRISH PILGRIMAGE TRUST.
I GIVE PERMISSION FOR THE TRUST TO USE PHOTOGRAPHIC MATERIALS IN ALL IT'S PUBLICATIONS, INCLUDING HARDCOPY, ELECTRIONIC AND INTERNET.

Signed: _____

Date: _____ / _____ / 20_____

VOLUNTEER CARERS MUST COMPLETE SECTION 26

26. IF YOU ARE TRAVELLING AS A VOLUNTEER CARER, PLEASE COMPLETE THIS SECTION AND SIGN THE DECLARATION STATEMENT IN SECTION 26

IF YOU HAVE BEEN A VOLUNTEER OR EMPLOYEE WITH ANY OTHER PILGRIMAGE OR ORGANISATION, PLEASE GIVE DETAILS ON ANY WORK OR INVOLVEMENT WITH YOUNG PEOPLE OR VULNERABLE ADULTS:

_____

_____

_____

TWO REFEREES REQUIRED—(NOT Related to you)

Please give the name, address and daytime phone number of someone who has experience of your involvement with young people or a Garda, Clergyman, Doctor, Solicitor, School Principal and who could supply a character reference:

A. Name: _____

Position: _____

Address: _____

_____

_____

Mobile Number: _____

B. Name: _____

Position: _____

Address: _____

_____

_____

Mobile Number: _____

In the event of an emergency, where urgent medical treatment is required, I authorise any one of the official Hosanna House Group Leaders of The Irish Pilgrimage Trust, Kilcuan, Clarinbridge, Galway to sign on my behalf any form of consent required by any medical authority.

The information provided by you on this Form may be used by The Irish Pilgrimage Trust to assist the Trustees and Group Leaders in deciding who best to nominate/choose as Carer / Guest on the Easter Pilgrimage, Hosanna House and/ or Friendship Weeks in Kilcuan / Cois Cuain.

The information may be disclosed to the Trust Medical Doctor, Trustees and Group Leaders.

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.

DECLARATION STATEMENT

THE FOLLOWING INFORMATION IS REQUIRED TO CONFORM WITH CHILD CARE LEGISLATION AND RECOMMENDED CODES OF PRACTICE:

Have you ever been, or are you currently, the subject of any investigation, complaint or disciplinary procedure, caution, or awaiting the outcome of any pending prosecution? **Yes** ☐ **No** ☐

Have you ever been convicted of a criminal offence, or been subject to caution or bind over against an individual or individuals?

Yes ☐ **No** ☐

Has an order ever been made against you removing a child from your care or from premises in which you live?

Yes ☐ **No** ☐

Has an order ever been made against you in respect of a child in your care which has been found to be in need of care, protection or control? **Yes** ☐ **No** ☐

I HEREBY DECLARE THAT THE DETAILS ON THIS FORM ARE CORRECT AT THE DATE GIVEN BELOW.

I have read and understood The Trust's Code of Practice and I am suitable in every way to perform the work and duties of a volunteer / carer.

I undertake to advise The Trust if any incident or occurrence arises, or is brought to my notice, between completion of this form and my participation in Trust activities, concerning matters referred to in Question 26 above.

I undertake to provide any further relevant information and advise The Trust on any changes after the date below in the information supplied on this form.

I will not use or bring any illegal substance on The Trust pilgrimage. I agree not to be under the influence of alcohol or any other substance which might reduce the standards of care and behaviour requested. I agree to comply with directions received from The Trust on these matters.

I will bring a valid European Health Insurance Card and current passport with me to Lourdes.

SIGNATURE: _____

PLEASE PRINT NAME: _____

_____

DATE: _____ / _____ / **20**_____

27. MEDICAL SECTION
TO BE COMPLETED BY DOCTOR

Dear Doctor,
The following information is required to establish the precise medical requirements of your patient while away with The Irish Pilgrimage Trust in Lourdes. All information will be treated confidentially. If you wish, this form may be sealed and sent directly to the Trust Medical Officer, The Irish Pilgrimage Trust, Kilcuan, Clarinbridge, Galway, H91 W596

Thank you for you help.

1. APPLICANT'S SURNAME:

_____

2. FORENAME:

_____

3. PRIMARY DIAGONSIS:

_____

4. OTHER DIAGONSIS:

_____

_____

_____

5. TO WHAT EXTENT IS APPLICANT AFFECTED ( ):

PHYSICALLY:

- ☐ NOT AFFECTED
- ☐ MILDLY AFFECTED
- ☐ MODERATELY AFFECTED
- ☐ SEVERLEY PHYSICALLY AFFECTED

LEARNING ABILITY:

- ☐ NORMAL ABILITY
- ☐ MILD LEARNING DISABILITY
- ☐ MODERATELY LEARNING DISABILITY
- ☐ SEVERE LEARNING ABILITY

6. TICK IF ANY OF THE FOLLOWING CONDITIONS ARE PRESENT:

- ☐ DIABETES
- ☐ NEURAL TUBE DEFECT (E.G. SPINA BIFIDA)
  - IS CSF SHUNT IN SITU? YES ☐ NO ☐
- ☐ HEART CONDITION
  - WHAT IS NATURE OF LESION? _____
- ☐ EPILEPSY / SEIZURES

PLEASE TICK TYPE:

- ☐ FEBRILE CONVULSIONS
- ☐ GRAND MAL
- ☐ PETIT MAL
- ☐ PARTIAL SEIZURES
- ☐ MYOCLONIC
- ☐ OTHER

WHEN WAS LAST SEIZURE? _____

HOW FREQUENT ARE ATTACKS? _____

- ☐ CYSTIC FIBROSIS
  - HAS PS.CEPACIA BEEN CULTURED? YES ☐ NO ☐
- ☐ COMPROMISED IMMUNE SYSTEM
- ☐ IMPAIRED SPEECH
- ☐ NO COMMUNICATION
- ☐ COMMUNICATES BY SIGNS
- ☐ INSITINCT SPEECH
- ☐ IMPAIRED SIGHT
- ☐ BLIND
- ☐ PARTIAL SIGHT
- ☐ IMPAIRED HEARING
- ☐ TOTAL DEAFNESS
- ☐ PARTIAL HEARING
- ☐ NERVOUS PROBLEMS
- ☐ HYPERACTIVE
- ☐ NERVOUS / ANXIOUS
- ☐ DEPRESSED
- ☐ PHYCHOTIC

7. ANY ALLERGY / DRUG SENSITIVITY?

_____

_____

_____

8. PLEASE LIST CURRENT MEDICATION / PRINTED COPY

_____

_____

_____

_____

_____

HAS PATIENT HAD ANY OF FOLLOWING

- ☐ STEROIDS
- ☐ CHEMOTHERAPY
- ☐ IMMUNOSUPRESSANTS

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

9. ADDITIONAL INFORMATION

PLEASE GIVE ANY FURTHER MEDICAL ADVICE OR INFORMATION WHICH MAY BE USEFUL (E.G.—DIET, SHUNTS, SPECIAL AIDS, ETC.)

_____

_____

10. WOULD YOU LIKE THE TRUST MEDICAL OFFICER TO CONTACT YOU REGARDING THIS APPLICATION?

☐ YES ☐ NO ☐ ONLY IF NECESSARY

11. IN MY OPINION, THE PERSON NAMED ABOVE IS MEDICALLY FIT TO TRAVEL TO LOURDES AS PART OF THE IRISH PILGRIMAGE TRUST PILGRIMAGE

SIGNED: _____

NAME: _____

DR. _____

DATE: _____

SURGERY STAMP