IHCPT – The Irish Pilgrimage Trust

Lourdes Easter Pilgrimage Application Form

Charity Number 5992

The Blue Section:

This section should be completed by a young person who wishes to travel to Lourdes with The Irish Pilgrimage Trust, or by another on their behalf.

PLEASE COMPLETE ALL QUESTIONS IN BLUE SECTION

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.

THE COMPLETION OF AN APPLICATION FORM DOES NOT GUARANTEE SELECTION

FOR IHCPT USE	
Form supplied by:	
Group/Region:	
Telephone No:	
2nd Inq	Reg
Received	Acknowledged

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

IHCPT – The Irish Pilgrimage Trust,
Kilcuan, Clarenbridge, Co Galway

The closing date for applications is 31st October

If you have any queries about your application, please contact The Irish Pilgrimage Trust at:

Tel: 091 796622   Fax: 091 796916
Email: info@irishpilgrimagetrust.com

The Irish Pilgrimage Trust welcomes applications from young people with:

A physical disability or illness (aged 9 - 18)

A learning disability (aged 11-21)

A physical disability or illness (aged 19- 30)

A learning disability (aged 22 - 30)

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 of Lourdes. Such applications should be accompanied by a written recommendation.

All the adult companions including Group Leaders, Doctors, Chaplins, Nurses and Carers must undergo vetting and they pay their own fare. Parents in Family Groups must also undergo vetting and are asked to pay carers fare (if possible). If the applicant is selected to travel to Lourdes, the Trust would welcome voluntary contributions from those in receipt of Disability Allowance.

PLEASE PRINT

1. SURNAME: ______________________

2. FORENAME: ______________________

3. DATE OF BIRTH: __________ ☐ MALE ☐ FEMALE

AGE NEXT BIRTHDAY ______________________

4. HOME ADDRESS: ______________________

____

____

5. CONTACT TELEPHONE NUMBER:

HOME ______________________

MOBILE ______________________

EMAIL ADDRESS ______________________

6. NEAREST TOWN TO HOME: ______________________

7. NATIONALITY OF APPLICANT: ______________________

PLACE OF BIRTH: ______________________

8. FATHER'S NAME: ______________________

FATHER'S OCCUPATION: ______________________

MOTHER'S NAME: ______________________

MOTHER'S OCCUPATION: ______________________

NUMBER OF SIBLINGS

BROTHERS __________ SISTERS __________

9. WITH WHOM DOES APPLICANT NORMALLY LIVE?

☐ Mother ☐ Father ☐ Both
☐ Guardian ☐ Other(s) ☐ Independently

NAME OF GUARDIAN, only if different from parents

10. NAME AND ADDRESS FOR CORRESPONDENCE:
(Only if different from above address)

11. HAS APPLICANT BEEN TO LOURDES BEFORE WITH THE TRUST? ☐ YES ☐ NO
IF "YES", GROUP NUMBER ______ YEAR ______

12. NAME AND ADDRESS OF SCHOOL/CENTRE/WORK:
(If Applicable)

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

13. IS THE APPLICANT IN RESIDENTIAL CARE?
☐ YES ☐ NO
IF "YES", HOW OFTEN DOES THE APPLICANT GO HOME?
☐ WEEKLY ☐ MONTHLY
☐ HOLIDAYS ☐ NEVER

14. HAS THE APPLICANT EVER BEEN IN RESPITE CARE?
☐ YES ☐ NO
IF "YES", PLEASE GIVE DETAILS

15. NAME OF APPLICANT'S FAMILY DOCTOR:
DR ______

TELEPHONE NUMBER: ______

16. NAME OF APPLICANT'S SPECIALIST:

DR ______

TELEPHONE NUMBER: ______

DOES APPLICANT ATTEND HOSPITAL REGULARLY?
☐ YES ☐ NO

HOSPITAL ______

TELEPHONE NUMBER: ______

WHEN WAS APPLICANT LAST IN HOSPITAL?

17. NAME OF SOCIALWORKER / PUBLIC HEALTH NURSE?

TELEPHONE NUMBER: ______

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 ☐ OTHER EQUIPMENT
☐ OXYGEN
PLEASE DETAIL: ______

THIS IS VERY IMPORTANT

WHAT IS THE APPLICANT'S WEIGHT? ______

IS THIS EXACT? ☐ **APPROXIMATE?** ☐

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

MEASLES INFECTION	☐ YES	☐ NO	☐ DON'T KNOW
CHICKEN POX INFECTION	☐ YES	☐ NO	☐ DON'T KNOW
MMR VACCINE	☐ YES	☐ NO	☐ DON'T KNOW
MEASLES VACCINE	☐ YES	☐ NO	☐ DON'T KNOW

27. HAS APPLICANT ANY SOCIAL, EMOTIONAL OR BEHAVIOURAL PROBLEMS?

☐ NORMAL	☐ WITHDRAWN	☐ HYPERACTIVE
☐ NERVOUS	☐ DISINHIBITED	☐ DEPRESSED
☐ SHY	☐ FRIENDLY	☐ PSYCHOSIS
☐ HAPPY	☐ EXCITABLE	☐ HYPERACTIVE
☐ TIRES EASILY	☐ EASILY UPSET	☐ INCLINED TO WANDER

TRIGGERS: ______________________________

____

FREQUENCY: ______________________________

HOW LONG DOES IT LAST? ______________________________

HOW DO YOU RESOLVE/MANAGE THIS BEHAVIOUR?

____

____

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

____

____

ESSENTIAL! TO BE COMPLETED ON BEHALF OF ALL APPLICANTS

I/WE HEREBY APPLY FOR THE ABOVE NAMED TO GO ON PILGRIMAGE TO LOURDES WITH:

IHCPT – 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 young person will not bring any unprescribed medication or illegal substances.

b: the above named young person will have a valid Passport and European Health Insurance Card. (EHIC)

c: In the event of an emergency, where urgent medical treatment is required, I/we authorise any one of the officials of IHCPT – The Irish Pilgrimage Trust, Kilcuan, Clarenbridge, Co Galway 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 necessaries, je/nous autorise/autorisons n'importe lequel des responsables suivants de IHCPT de signer à mon nom un formulaire de consentement exigé par les responsables médicaus.
Trust Doctor /Nurse/ National Co-ordinator /Chairperson

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

I/WE GIVE PERMISSION FOR THE TRUST TO USE PHOTOGRAPHIC MATERIAL IN THE ORGANISATION'S PUBLICATIONS.

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
IHCPT - THE IRISH PILGRIMAGE TRUST
KILCUAN, CLARENBRIDGE, CO. GALWAY

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

☐ NO PHYSICAL DISABILITY

☐ MILD PHYSICAL DISABILITY

☐ MODERATE PHYSICAL DISABILITY

☐ SEVERE PHYSICAL DISABILITY

LEARNING DISABILITY

☐ NORMAL ABILITY

☐ MILD LEARNING DISABILITY

☐ MODERATE LEARNING DISABILITY

☐ SEVERE LEARNING DISABILITY

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

☐ MENTAL HEALTH

☐ 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:

☐ 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?

MEASLES INFECTION	☐ YES	☐ NO	☐ DON'T KNOW
CHICKEN POX INFECTION	☐ YES	☐ NO	☐ DON'T KNOW
MMR VACCINE	☐ YES	☐ NO	☐ DON'T KNOW
MEASLES 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.)

____

____

____

____

____

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

☐ YES ☐ ONLY IF NECESSARY

SIGNED: ______________________

DATE: _____ / _____ / _____

SURGERY STAMP

THANK YOU!