The Irish Pilgrimage Trust

APPLICATION FORM

The Irish Pilgrimage Trust, Kilcuan, Clarinbridge, Galway, H91 W596
Tel. 091 796622

Charity Registration Number: 20009953
Rev. Number: CHY 5992

Email: info@irishpilgrimagetrust.com
Web: www.irishpilgrimagetrust.com

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 best to take as Guests on our Easter Pilgrimages to Lourdes, Hosanna House and on holiday to Kilcuan, Galway and Cois Cuain, Wexford during the Friendship Weeks. You, as the provider of the information are entitled to a copy of the information on request. You, as 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 on this information on request.

DATA PROTECTION STATEMENT

The Irish Pilgrimage Trust will only process your information for the reason / extension of the reason that it was obtained. Your data will not be passed onto third parties or accessed by any unauthorised individuals. Your data will be stored securely and will be processed in association with relevant GDPR and Data Protection legislation.

By signing this APPLICATION FORM you agree to allow the processing of your data by The Irish Pilgrimage Trust.

For Office Use Only	I.D. No.
*Supplied By:*_____	
*Telephone No.:*_____	
2nd Inq.	Region

ALL Trust VOLUNTEERS undergo vetting and pay their own fare

COMPLETION OF AN APPLICATION FORM DOES NOT GUARANTEE SELECTION

PLEASE TICK WHICH ONE YOU ARE APPLYING FOR

☐ **EASTER PILGRIMAGE to LOURDES - Closing Date :- 31st October**
For Children / Young People with Special Needs, age 11 - 30 years; For Children with serious or terminal illness up to age 11, accompanied by a parent or guardian; Applicant, if selected, will join the Trust Pilgrimage to Lourdes as our Guest

☐ **FRIENDSHIP WEEKS Summer, Kilcuan, Galway and Cois Cuain, Wexford - Closing Date :- 31st May**
For Children/Young people and older adults with special needs who contribute to the cost of the week

☐ **Summer LOURDES Pilgrimage staying in Hosanna House, Bartres - Closing Date :- 31st May**
For young people and adults with Special Needs who pay their own fare.

The Irish Pilgrimage Trust is totally dependent on fundraising. Any donation would be gratefully received

Use Block Capitals Please **Pages 1 - 3 All Sections to be completed and signed by Applicant**

SECTION 1 Applicant Name

1. FIRST NAME: _____

2. SURNAME:_____

3. D.O.B. _____/_____/_____AGE:_____
Day Month Year

4. GENDER _____

5. ADDRESS:_____

_____

_____

_____POST CODE:_____

EMAIL ADDRESS: _____

_____

6. APPLICANT Contact Number_____

7. VALID PASSPORT: ☐ YES ☐ NO

8. APPLICANT'S NATIONALTY:_____

9. First Parent's Name:_____

First Parent's Contact No.:_____

10. Second Parent's Name:_____

Second Parent's Contact No.:_____

11. NAME OF GUARDIAN, only if different from parents

_____

Guardian Contact No. :_____

12. WITH WHOM DOES APPLICANT NORMALLY LIVE?

☐ Mother ☐ Father ☐ Both
☐ Guardian ☐ Other ☐ Independently

If Other, please state: _____

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

_____

_____

_____POST CODE_____

SECTION 2 - General Information

14. Has APPLICANT been to Lourdes before with The Irish Pilgrimage Trust? ☐ YES ☐ NO

If "YES", GROUP NUMBER:_____YEAR:_____

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

_____

_____

_____

_____

Phone No. of School / Centre / Work:_____

Name of TEACHER / PRINCIPAL / EMPLOYER:

_____

PLEASE INDICATE THE TYPE OF SCHOOL/CENTRE/WORK:

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

16. Is APPLICANT in Residential Care?
☐ YES ☐ NO

If "YES" how often does the APPLICANT go Home?
☐ WEEKLY ☐ MONTHLY
☐ HOLIDAYS ☐ NEVER

17. Has APPLICANT ever been in Respite Care?
☐ YES ☐ NO

If "YES", please give details:_____

_____

_____

18. NAME OF SOCIAL WORKER / PUBLIC HEALTH NURSE

_____

PHONE NUMBER: _____

SECTION 3 - Additional Information

19. List Applicant's HOBBIES / INTERESTS, or any other Information which might be of help:

_____

_____

_____

20. Which of the following best describes the APPLICANT? *Please, Tick as many as you wish*

☐ Nervous ☐ Hyperactive ☐ Shy
☐ Happy ☐ Excitable ☐ Withdrawn
☐ Disinhibited ☐ Depressed ☐ Tires Easily
☐ Easily Upset ☐ Inclined To Wander

21. Has APPLICANT any social, emotional or behavioural problems?
☐ Bites ☐ Temper
☐ Hits Out ☐ Aggression

What might cause these difficulties? How often do they occur?

_____

_____

_____

_____

_____

_____

_____

What works best in resolving these difficulties?

_____

_____

_____

_____

_____

_____

22. Does the APPLICANT get help of any kind (School Support, Social Worker, CAMHS, other) or have they had in the past?

_____

_____

_____

_____

_____

_____

_____

23. If the APPLICANT has neither a physical disability nor a learning disability why do you think the APPLICANT should be considered for the trip?

_____

_____

_____

_____

_____

_____

_____

_____

24. NAME OF APPLICANT'S FAMILY DOCTOR:

DR._____

DOCTORS PHONE NUMBER:_____

25. APPLICANT'S DIAGNOSIS: (Block Capitals please): _____

_____

_____

_____

_____

26. TO WHAT EXTENT IS APPLICANT AFFECTED:

PHYSICAL DISABILITY

- ☐ MILD PHYSICAL DISABILITY
- ☐ MODERATE PHYSICAL DISABILITY
- ☐ SEVERE PHYSICAL DISABILTY

LEARNING DISABILITY

- ☐ MILD LEARNING DISABILITY
- ☐ MODERATE LEARNING DISABILITY
- ☐ SEVERE LEARNING DISABILITY

27. **WHAT IS THE APPLICANT'S WEIGHT IN kg? (Divide total pounds by 2.2 = KG)?**_____

28. TICK if any of the following is / are present:

- ☐ NEUTRAL TUBE DEFECT (e.g. Spina Bifida / Hydrocephalus)
- ☐ CYSTIC FIBROSIS
- ☐ COMPROMISED IMMUNE SYSTEM
- ☐ ADHD / ADD / ODE
- ☐ MENTAL HEALTH ISSUES
- ☐ ASPERGERS
- ☐ COELIAC DISEASE
- ☐ AUTISM

29. If DIABETES is present

☐ TYPE 1 ☐ TYPE 2 ☐ INSULIN PUMP

30. EPILEPSY SEIZURES
Which type of Epilepsy / Seizures

- ☐ Febril Convulsions
- ☐ Myoclonic
- ☐ Partial Seizures
- ☐ Petit Mal
- ☐ Grand Mal
- ☐ Other

If Other, please give details _____

_____

_____

_____

When was last seizure? _____

How frequent are seizures? _____

31. HEART CONDITION

Nature of HEART Condition _____

_____

_____

32. Is the APPLICANT on Medication?

☐ YES ☐ NO

If YES, Please provide copy of your perscription or List of Medication

33. Any Allergy / Sensitivity?

- ☐ LATEX
- ☐ FOOD
- ☐ DRUG
- ☐ OTHER

If Allergy / Sensitiveity please give details - _____

_____

_____

Do you have an Epipen?

☐ YES ☐ NO

34. DIET

- ☐ Normal
- ☐ Liquidised
- ☐ Peg
- ☐ Sloppy
- ☐ Nasogastic
- ☐ Other

Please state e.g. Low Salt, Gluten Free etc. _____

_____

35. Please TICK if the APPLICANT has had the following:

- ☐ Chicken Pox Infection
- ☐ Tetanus
- ☐ MMR Vaccine
- ☐ Don't know

36. COVID - 19 Vaccination

☐ YES ☐ NO

**** **If YES please provide copy of your Covid Certificate**

37. Name of APPLICANT'S Specialist(s) and which Hospital?

_____

_____

_____

Phone Number of Specialist _____

38. Does the APPLICANT attend Hospital Regularly?

☐ YES ☐ NO ☐ YES, as Outpatient

If YES, name of Hospital and Why? _____

_____

_____

39. What SURGERY has APPLCANT had and When? _____

_____

_____

40. What SURGERY or othe Medical Treatment is planned and When?

_____

_____

41. Has APPLICANT had any of the following in the past year
☐ Chemotherapy ☐ Immunosuppressents
☐ Steroids

Please give date of the last occasion.. _____

_____

42. Is Speech Impared?
☐ YES ☐ NO

43. If YES to Speech Impared
☐ No Communication ☐ Communication by Signs
☐ Indistinct Speech ☐ Lip Reads

44. APPLICANT'S Sight
☐ Normal ☐ Partial Sight
☐ Blind ☐ Wears Glasses

APPLICANT'S Sight - Additional Information _____

_____

_____

45. APPLICANT Hearing
☐ Normal ☐ Hard of Hearing
☐ Total Deafness ☐ Cochlear Implant

APPLICANT Hearing - Additional information_____

_____

46. Is APPLICANT Incontinent?
☐ YES ☐ NO

47. Does APPLICANT use any of the following?
☐ No Equipment required ☐ Buggy
☐ Walking AIds ☐ Crutches
☐ Inhalers / Nebulisers ☐ Splints
☐ Hoist ☐ Bed Rails
☐ Hearing Aids ☐ Wheelchair
☐ CPAP Machine ☐ Implantable Device

48. If APPLICANT uses a Wheelchair please select -
☐ Sometimes ☐ Always
☐ Manual ☐ Electric

49. Other equipment, please give details_____

_____

_____

Is Oxygen required?
☐ Never ☐ Sometimes ☐ Always

50. Please list any additional Medical Information which may be useful

_____

_____

THIS SECTION MUST BE COMPLETED & SIGNED BY / ON BEHALF OF THE APPLICANT

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:

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

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

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

I / WE GIVE FULL PERMISSION TO THE TRUST 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 Applicant will not bring unprescribed medication or illegal substances on the pilgrimage.

b. I / We shall advise the Trust if there is any change in my / the above named applicant's condition or medications between now and the Easter pilgrimage to Lourdes / Summer FW to Kilcuan / Cois Cuain / Summer Lourdes HH

I / WE UNDERSTAND THAT THE APPLICANT'S IMAGE MAY BE CONTAINED AND USED IN PHOTOGRAPHIC AND VIDEO MATERIAL PUBLISHED BY THE TRUST IN ALL IT'S PUBLICATIONS INCLUDING HARDCOPY, ELECTRONIC AND INTERNET. ☐

DATA PROTECTION :- By signing below I / you agree to allow the processing of my data by The Irish Pilgrimage Trust as oulined on Page 1.
WITHDRAWAL OF CONSENT :- I/ We understand that consent may be withdrawn at any time by submitting written notification of such to the Trust's National Co-ordinator at the head office of The Irish Pilgrimage Trust, Kilcuan, Clarinbridge, Galway, H91 W596

By SIGNING this Application Form I / We hereby agree with the Statements and Terms contained herein and above and I /we confirm that, to the best of my/our knowledge, all information provided is correct and accurate at the time of completing this Application Form.
I / we understand that completing, signing and submitting this Application Form does not guarantee selection.

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

1._____ 2. _____ 3. _____

RELATION TO APPLICANT_____RELATION TO APPLICANT_____APPLICANT_____

DATE: _____/_____/_____ DATE:_____/_____/_____ DATE: _____/_____/_____
Day Month Year Day Month Year Day Month Year