The Irish Pilgrimage Trust
APPLICATION FORM

The Irish Pilgrimage Trust, Kilcuan, Clarinbridge, Galway, H91 W596
Tel. 091 796622 Fax 091 796916

Charity Registration Number: 20009953
Rev. Number: CHY 5992

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

The Blue Section:

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

PLEASE COMPLETE ALL QUESTIONS IN THE BLUE SECTION

FOR OFFICE USE	
Supplied By:_____	
Telephone No.:_____	
2nd Inq.	**Region**

The Red MEDICAL Section:

All applicants must have the red MEDICAL 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

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 best to take as Guests in the Easter 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 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.

THE COMPLETION OF AN APPLICATION FORM DOES NOT GUARANTEE SELECTION

The Irish Pilgrimage Trust welcome applications from young people with:

A physical disability or illness or learning disability (aged 11 - 30 years)
A serious or terminal 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 nor learning disability but whom the Trust believes would benefit from the experience of Lourdes. Such applications MUST be accompanied by a written submission.

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

PLEASE PRINT

1. SURNAME: _____

2. FORENAME:_____

3. D.O.B. _____/_____/_____AGE:_____M ☐ F ☐

4. ADDRESS:_____

_____

_____

_____

_____POST CODE:_____

5. VALID PASSPORT: YES ☐ NO ☐

6. APPLICANT'S NATIONALTY:_____

7. MOTHERS NAME:_____

CONTACT PH. NUMBER :_____

EMAIL ADDRESS: _____

FATHERS NAME:_____

CONTACT PH. NUMBER:_____

8. NAME OF GUARDIAN, only if different from parents

_____

CONTACT PH. NUMBER :_____

9. WITH WHOM DOES APPLICANT NORMALLY LIVE?

☐ Mother ☐ Father ☐ Both

☐ Guardian ☐ Other ☐ Independently

10. NAME AND ADDRESS FOR CORRESPONDENCE:
(*Only if different from Home 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:

_____

_____

TELEPHONE NUMBER:_____

TEACHER / PRINCIPAL / EMPLOYER NAME:

_____

PLEASE INDICATE THE TYPE OF SCHOOL/CENTRE/WORK:

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

13. IS APPLICANT IN RESIDENTIAL CARE?

☐ YES ☐ NO

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

- ☐ WEEKLY
- ☐ MONTHLY
- ☐ HOLIDAYS
- ☐ NEVER

14. HAS 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 THE APPLICANT ATTEND HOSPITAL REGULARLY?

☐ YES ☐ NO

HOSPITAL:_____

TELEPHONE NUMBER:_____

WHEN WAS APPLICANT LAST IN HOSPITAL? _____

_____

17. NAME OF SOCIAL WORKER / PUBLIC HEALTH NURSE

_____

TELEPHONE NUMBER: _____

18. DOES APPLICANT REQUIRE ASSISTANCE WITH:

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

(*please indicate level of assistance needed*)

_____

_____

19. SPEECH:

IS SPEECH IMPARED ☐ YES ☐ NO

IF "YES"

- ☐ NO COMMUNICATION
- ☐ COMMUNICATION BY SIGNS
- ☐ INDISTINCT SPEECH
- ☐ LIP READS

20. SIGHT:

- ☐ NORMAL)
- ☐ PARTIAL SIGHT) IN
- ☐ BLIND)

☐ BOTH ☐ LEFT ☐ RIGHT

21. HEARING:

- ☐ NORMAL)
- ☐ HARD OF HEARING) IN
- ☐ TOTAL DEAFNESS)

☐ BOTH ☐ LEFT ☐ RIGHT

22. IS APPLICANT INCONTINENT?

☐ NIGHT ☐ DURING DAY

23. DOES APPLICANT USE ANY OF THE FOLLOWING?

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

PLEASE DETAIL:_____

_____

24. DIET

☐ NORMAL ☐ SLOPPY ☐ LIQUIDISED
☐ NASOGASTRIC ☐ PEG

WHAT FEED IS USED? _____

_____

25. PLEASE LIST ALL MEDICATION BEING TAKEN: _____

_____

_____

_____

_____

_____

26. PLEASE LIST ALLERGIES: _____

_____

_____

_____

27. HAS APPLICANT HAD ANY OF THE FOLLOWING?

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

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

_____

_____

29. 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 DO THEY OCCUR? _____

_____

WHAT WORKS BEST IN RESOLVING THESE DIFFICULTIES?

_____

30. IF THE APPLICANT HAS NEITHER A PHYSICAL DISABILITY NOR A LEARNING DISABILITY WHY DO YOU THINK THE APPLICANT SHOULD BE CONSIDERED FOR THE TRIP?

_____

_____

_____

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

ESSENTIAL! MUST BE COMPLETED BY / 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 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, 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

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

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

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

1._____ 2. _____ 3. _____

RELATION TO APPLICANT_____RELATION TO APPLICANT_____APPLICANT_____

DATE: _____/_____/_____ DATE:_____/_____/_____ DATE: _____/_____/_____

WITHDRAWAL OF CONSENT: I/ We understand that I/we can withdraw my consent 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

1._____ 2. _____ 3. _____
RELATION TO APPLICANT_____RELATION TO APPLICANT_____APPLICANT_____

MEDICAL SECTION - TO BE COMPLETED BY THE APPLICANT'S 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 RETURNED DIRECTLY TO
THE TRUST MEDICAL DOCTOR, THE IRISH PILGRIMAGE TRUST, KILCUAN, CLARINBRIDGE, GALWAY, H91 W596.
THANK YOU FOR YOUR HELP

1. APPLICANT'S SURNAME: _____

2. FORENAME: _____

3. D. O. B. _____

4. DIAGNOSIS: (Block Capitals please)_____

_____

_____

5. TO WHAT EXTENT IS APPLICANT AFFECTED:

PHYSICAL DISABILITY

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

LEARNING DISABILITY

- ☐ MILD
- ☐ MODERATE
- ☐ SEVERE

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

- ☐ DIABETES
- ☐ NEUTRAL TUBE DEFECT (E.G. 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

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

WHEN WAS LAST SEIZURE?_____

HOW FREQUENT ARE SEIZURES? _____

7. PLEASE LIST CURRENT MEDICATION / PRINTED COPY:

_____

_____

_____

_____

_____

_____

8. ANY DRUG / ALLERGY SENSITIVITY? _____

_____

_____

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

- ☐ CHEMOTHERAPY
- ☐ IMMUNOSUPPRESSANTS
- ☐ STEROIDS

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

10. IS OXYGEN REQUIRED?

☐ NEVER ☐ SOMETIMES ☐ ALWAYS

11. WHAT SURGERY HAS APPLICANT HAD? AND WHEN?

_____

_____

WHAT SURGERY IS PLANNED? AND WHEN?

_____

_____

12. VACCINATIONS: HAS APPLICANT HAD?:

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

MMR VACCINE ☐ YES ☐ NO ☐ DON'T KNOW

DATE OF LAST TETANUS:_____/_____/_____

13. 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** ☐

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

☐ YES ☐ ONLY IF NECESSARY

SIGNED: _____

DATE: _____/_____/_____

SURGERY STAMP *(ESSENTIAL)*

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