



The Irish Pilgrimage Trust

APPLICATION FORM



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

Charity Registration Number: 20009953
Revenue 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 of 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.	
Region		GROUP	
DB	SCAN	PP	EHIC

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 :- 15th October** *N.B. Valid Passport & EHIC required
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. *N.B. Valid Passport & EHIC required

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

**You must complete ALL sections for your Application to be considered.
Use Block Capitals Please**

SECTION 1 Applicant

1. FIRST NAME: _____

2. SURNAME: _____

3. D.O.B. ____/____/____ AGE: _____
Day Month Year

4. GENDER _____

5. ADDRESS: _____

POST CODE: _____

6. EMAIL For ALL Correspondence _____

7. APPLICANT'S Contact Number _____

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 the Applicant been out of the country before?
 YES NO

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 DAY SERVICE

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: _____

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
- Hair Pulling

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. _____

DOCTOR'S PHONE NUMBER: _____

GMS / NHS NUMBER: _____

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

26. Is the APPLICANT on MEDICATION ?

YES NO

If YES, Please provide copy of your perscription and List Medications

27. Is OXYGEN required ?

Never Sometimes Always

28. THE APPLICANT'S WEIGHT IN kg?

(Divide total pounds by 2.2 = Kg)? _____

29. TO WHAT EXTENT IS APPLICANT AFFECTED:

PHYSICAL DISABILITY

LEARNING DISABILITY

MILD MILD
 MODERATE MODERATE
 SEVERE SEVERE

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

- NEURAL TUBE DEFECT (e.g. Spina Bifida / Hydrocephalus)
- CYSTIC FIBROSIS
- COMPROMISED IMMUNE SYSTEM
- MENTAL HEALTH ISSUES
- ASPERGERS
- AUTISM

31. If DIABETES is present

TYPE 1 TYPE 2 INSULIN PUMP

32. EPILEPSY SEIZURES

Which type of Epilepsy / Seizures

Febril Convulsions Tonic
 Myoclonic Atonic
 Tonic Clonic Absence

If Other, please give details _____

When was last seizure? _____

How frequent are seizures? _____

33. HEART CONDITION

Nature of HEART Condition : _____

34. Any Allergy / Sensitivity ?

LATEX DRUG INSECT BITES
 FOOD OTHER

If Allergy / Sensitivity please give details - _____

35. DO YOU USE AN EPIPEN ?

YES NO

36. DIET

Normal Sloppy
 Liquidised Nasogastic
 Peg Coeliac Disease
 Other

Please state e.g. Low Salt, Gluten Free, Thickening Agent _____

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

Chicken Pox Infection MMR Vaccine
 Chicken Pox Vaccine Covid-19 Vaccine
 Tetanus Vaccine Don't know

38. Does the APPLICANT attend Hospital Regularly?

YES NO YES, as Outpatient

If YES, name of Hospital and Why? _____

39. Name of APPLICANT'S Specialist(s)

Phone Number of Specialist _____

40. What SURGERY has APPLICANT had and When? _____

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

42. Has APPLICANT had any of the following in the past year

- Chemotherapy
- Immunosuppressants
- Steroids

Please give date of the last occasion.. _____

43. Is Speech Impaired?

- YES
- NO

44. If YES to Speech Impaired

- No Communication
- Communication by Signs
- Indistinct Speech
- Lip Reads
- Communication Passport
- LÁMH

45. APPLICANT'S Sight

- Normal
- Partial Sight
- Blind
- Wears Glasses

APPLICANT'S Sight - Additional Information _____

46. APPLICANT Hearing

- Normal
- Total Deafness
- Hard of Hearing
- Hearing Aids
- Cochlear Implant / BAHA

APPLICANT Hearing - Additional information _____

47. Is APPLICANT Incontinent?

- YES
- NO

48. Does APPLICANT use any of the following?

- No Equipment required
- Buggy
- Walking Aids / Rolator
- Crutches
- Inhalers / Nebulisers
- Splints
- Hoist
- Bed Rails
- Wheelchair
- Implantable Device
- CPAP Machine

Can the APPLICANT Walk?

- YES
- NO

49. If APPLICANT uses a WHEELCHAIR please select -

- On Occassion
- Fulltime User
- Manual
- Electric

50. Would you like to add any additional information?

SECTION 3 - 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, où des soins médicaux urgents seraient nécessaires, je / nous autorise / autorisons n'importe lequel des responsables suivants de The Irish Pilgrimage Trust listés ci-dessous de signer à mon nom un formulaire de consentement exigé par les responsables médicaux.*

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 outlined 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.

Note: Additional Information will be requested by email on certain Medical conditions and / or Equipment.

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