The Irish Pilgrimage Trust
APPLICATION FORM

The Irish Pilgrimage Trust, Kilcuan, Clarinbridge, Galway, H91 W596
Tel. 00 353 91 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 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

SUBMISSION 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 / GHIC required**
For Children / Young People with Additional Needs, age 11 - 30 years; For younger 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
N.B. If you use a HOIST at home we will be unable to facilitate your needs in Lourdes
N.B. If you have travelled on our Lourdes Easter trip, please leave a gap of 5 years before you reapply.

☐ **FRIENDSHIP WEEKS, Summer in Kilcuan, Clarinbridge, Galway - 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 / GHIC 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.** ______/______/______ (Day / Month / Year) AGE: ________

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*)

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____________________ 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:**

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____

____

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 ☐ DAY SERVICE
☐ WORKPLACE ☐ NONE OF THESE

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 - General 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
☐ Hair Pulling

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

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What works best in resolving these difficulties?

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

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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?

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SECTION 4 - Medical Information

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

____

____

____

____

DO YOU USE AN INHALER ?

☐ YES ☐ NO

If YES give details of INHALER

____

27. **Is OXYGEN required ?**

☐ Never ☐ Sometimes ☐ Always

28. **THE APPLICANT'S WEIGHT IN kg?**
(Divide total pounds by 2.2 = Kg)?__________________________

29. T**O 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 ☐ Other

If Other, please give details ______________________________

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____

____

When was last seizure? __________________________________

How frequent are seizures? _______________________________

33. **HEART CONDITION**

☐ YES ☐ NO

Nature of HEART Condition :______________________________

____

____

34. **Any Allergy / Sensitivity** ?

☐ LATEX ☐ DRUG ☐ INSECT BITES
☐ FOOD ☐ OTHER

If Allergy / Sensitiveity please give details - ______________

____

____

35. **DIET**

☐ Normal ☐ Sloppy
☐ Liquidised ☐ Nasogastic
☐ Peg ☐ **Coeliac Disease**
☐ Other

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

____

36. **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

37. Does the APPLICANT attend Hospital Regularly?

☐ YES ☐ NO ☐ YES, as Outpatient

If YES, name of Hospital and Why? ______________________

____

____

38. **Name of APPLICANT'S Specialist(s)**

____

____

____

Phone Number of Specialist ___________________________________

39. What SURGERY has APPLCANT had and When? ________

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____

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 Impaired?
- ☐ YES
- ☐ NO

43. If YES to Speech Impaired
- ☐ No Communication
- ☐ Communication by Signs
- ☐ Indistinct Speech
- ☐ Lip Reads
- ☐ Communication Passport
- ☐ LÁMH

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

APPLICANT'S Sight - Additional Information _________________

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____

45. APPLICANT Hearing
- ☐ Normal
- ☐ Total Deafness
- ☐ Hard of Hearing
- ☐ Hearing Aids
- ☐ **Cochlear Implant / BAHA**

APPLICANT Hearing - Additional information___________________

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46. Is APPLICANT Incontinent?
- ☐ Night
- ☐ During Day

47. Does APPLICANT use any of the following?
- ☐ No Equipment required
- ☐ **BUGGY**
- ☐ **WALKING AIDS**
- ☐ Crutches
- ☐ **NEBULISERS**
- ☐ Splints
- ☐ Bed Rails
- ☐ **Wheelchair**
- ☐ **IMPLANTABLE DEVICE**
- ☐ **CPAP Machine**
- ☐ **MOBILITY SCOOTER**
- ☐ **ROLATOR**

Can the APPLICANT Walk?
- ☐ YES
- ☐ NO

48. **If APPLICANT uses a WHEELCHAIR please select** -
- ☐ On Occassion
- ☐ Fulltime User
- ☐ Manual
- ☐ Electric

(**Electric** - Additional technical information will be requested)

49. Would you like to add any additional information?

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____

____

SECTION 5 - 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 messesaries, 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.

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