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
Page 4 - Red MEDICAL SECTION must be completed by Applicant's Doctor.

1. FIRST NAME: ____________________

2. SURNAME: ____________________

3. D.O.B. ____ / ____ / ____ AGE: ____ M ☐ F ☐
Day Month Year

4. ADDRESS: ____________________

____

____

____

____________ POST CODE: ________

EMAIL ADDRESS: ____________________

5. VALID PASSPORT: ☐ YES ☐ NO

6. APPLICANT'S NATIONALTY: ____________________

7. MOTHERS NAME: ____________________

CONTACT PH. NUMBER : ____________________

8. FATHERS NAME: ____________________

CONTACT PH. NUMBER: ____________________

9. NAME OF GUARDIAN, only if different from parents

____

CONTACT PH. NUMBER : ____________________

10. WITH WHOM DOES APPLICANT NORMALLY LIVE?

☐ Mother ☐ Father ☐ Both

☐ Guardian ☐ Other ☐ Independently

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

____

____

____

____________ POST CODE: ________

12. HAS APPLICANT BEEN TO LOURDES BEFORE WITH THE TRUST? ☐ YES ☐ NO

IF "YES", GROUP NUMBER:________________YEAR:__________

13. 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

14. IS APPLICANT IN RESIDENTIAL CARE?
☐ YES ☐ NO

IF "YES" HOW OFTEN DOES THE APPLICANT GO HOME?
☐ WEEKLY ☐ MONTHLY
☐ HOLIDAYS ☐ NEVER

15. HAS APPLICANT EVER BEEN IN RESPITE CARE?
☐ YES ☐ NO

IF "YES", PLEASE GIVE DETAILS:__________________________

____

____

16. NAME OF APPLICANT'S FAMILY DOCTOR:

DR.____

TELEPHONE NUMBER:______________________________

17. 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? ____________

____

18. NAME OF SOCIAL WORKER / PUBLIC HEALTH NURSE

____

TELEPHONE NUMBER: ______________________________

19. DOES APPLICANT REQUIRE ASSISTANCE WITH:

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

(*please indicate level of assistance needed*)

____

____

20. SPEECH:
IS SPEECH IMPARED ☐ YES ☐ NO
IF "YES"
☐ NO COMMUNICATION ☐ COMMUNICATION BY SIGNS
☐ INDISTINCT SPEECH ☐ LIP READS

21. SIGHT:
☐ NORMAL) ☐ BOTH
☐ PARTIAL SIGHT) IN ☐ LEFT
☐ BLIND) ☐ RIGHT

22. HEARING:
☐ NORMAL) ☐ BOTH
☐ HARD OF HEARING) IN ☐ LEFT
☐ TOTAL DEAFNESS) ☐ RIGHT

23. IS APPLICANT INCONTINENT?
☐ NIGHT ☐ DURING DAY

24. DOES APPLICANT USE ANY OF THE FOLLOWING?
☐ HEARING AIDS ☐ OXYGEN
☐ BUGGY ☐ WALKING AIDS
☐ CRUTCHES ☐ CALIPERS
☐ INHALERS ☐ HOIST
☐ BED SIDES ☐ OTHER EQUIPMENT

PLEASE DETAIL:_________________________________

____

25. WHEELCHAIR - DOES APPLICANT USE A WHEELCHAIR?

IF YES, ☐ SOMETIMES ☐ ALWAYS

TYPE : ☐ MANUAL ☐ ELECTRICAL

26. DIET
☐ NORMAL ☐ SLOPPY ☐ LIQUIDISED
☐ NASOGASTRIC ☐ PEG

27. PLEASE LIST FOOD ALLERGIES (IF ANY): ____________

____

____

____

28. PLEASE LIST ALL MEDICATION BEING TAKEN: _________

____

____

____

____

____

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29. 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

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

____

____

31. 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

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

____

____

____

WHAT MIGHT CAUSE THESE DIFFICULTIES?______________

____

____

____

HOW OFTEN DO THEY OCCUR? ______________

____

WHAT WORKS BEST IN RESOLVING THESE DIFFICULTIES?

____

____

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

____

____

____

____

____

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 mecessaries, 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: ____/____/____ (Day / Month / Year)	DATE: ____/____/____ (Day / Month / Year)	DATE: ____/____/____ (Day / Month / Year)

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 / ATTACH 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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