APPLICATION FORM

Child's Information			
Full Name:		Preferred Name:	
Nature of illness or disability:			
Sex (please tick): Male □ Female□ Other □ please specify _____		Date of Birth:	
Height:	Weight:	Clothing Size: (Adult/Child):	
Does your child speak and understand English?	Please tick	Yes □	No □
Does your child have a passport?	Please tick	Yes □	No □
Has your child been on an overseas trip before?	Please tick	Yes □	No □
If yes, please provide details, if Australia, please be specific of areas visited and activities undertaken:			

Parent or Guardian Information		
Title: Mr/Mrs/Ms/Miss	Surname:	First Name(s):
Are you a Parent □ or Guardian □ (please tick)		
Street Number & Name:		
Suburb:		
Town/City		
Postcode		
Email		
Telephone: Home (0)	Business: (0)	Mobile: (02)

Medical Contact Information		
GP's Name:		Telephone Number (0)
Address		
Specialist's Name:		Telephone Number (0)
Address		

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When was your child last hospitalized?	
What was the reason?	

General Information (to be completed by Parent of Guardian)

Does your child require any special assistance? *(i.e. Peak flow, Physio, Dressings, Catheters, Night nappies etc)*	Please tick:	Yes □	No □
If yes, please specify			

Does your child need or use any of the following:		
Hearing Aids? Yes □ No □	Artificial Limbs Yes □ No □	Glasses/Contact Lenses Yes □ No□
Other (Please specify):		

Does your child need or use a wheelchair?	Yes □	No □	Sometimes □
If yes or sometimes, please specify:			

What supplies or equipment will be accompanying your child?
(e.g. Wheelchair, incontinence pads, bed sheets, dressing pads, nebulizers, physio wedge, etc)

Please specify:	

Continence

Is bed-wetting a problem?	Please tick	Yes □	No □
Does your child have 'accidents' during the day?	Please tick	Yes □	No □
If yes to either of the above, please give details			

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General Ability Information						
Key: 1 – Maximum supervision required, 2 – Supervision required, 3 – Minimal Supervision Required, 4 – Independent (please tick as applicable)						
Activity	1	2	3	4	N/A	Comments
Medications						
Personal Hygiene/Grooming						
Bathing/Showering						
Toileting						
Dressing						
Meals						
Communication						
Mobility (Indoors/Outdoors)						
Transfers (Bed/Chair/Toilet/Bus)						

Please describe your child's temperament (Outgoing, reserved, bossy, shy, etc)
Does your child require any special monitoring? Please tick Yes □ No □
(If yes, please specify)
Does your child have any special sleeping patterns or needs? Please tick Yes □ No □
(If yes, please specify)
Is there any other information that will assist us in caring for your child?
Can you please indicate how you may be able to help us with fundraising?
Does your child like theme park rides (if medically allowed)? Please tick Yes □ No □
Does your child like to try new things? Please tick Yes □ No □
Does your child like to get involved in group activities? Please tick Yes □ No □
I would like my details to go on the group mailing list (this is just so families can get in touch with each other) Please tick Yes □ No □

APPLICATION FORM

Consents

I, _____, parent/guardian of _____, hereby give Koru Care Otago my permission to use any photographs, film or video taken by them or their sponsors of

_____ on their Gold Coast trip for the specific purpose of promoting, advertising or displaying the Trust's activities.

Signed Print Name Date

I, _____, parent/guardian of _____, hereby give Koru Care Otago my permission for them to contact my child's school to discuss any relevant aspects regarding their participation in a Koru Care trip.

Name of School _____ Telephone (03) _____

Teacher's Name _____ _____

_____ Principal's Name _____

Signed Print Name Date

I, _____, parent/guardian of _____, understand that should my child be withdrawn from a trip for any other reason other than a medical or family emergency, any expenses incurred by Koru Care Otago relating to my child may be passed on to me.

Signed Print Name Date

I, _____, parent/guardian of _____, understand that my child may not bring a phone or other electronic device on the trip.

I also understand that if my child has an injury prior to departure and ends up in a cast or other medical device (moon boot, wrist strapping), I will advise Koru Care Otago ASAP. Your child may need to be moved to a future trip as the park's health and safety do not allow patrons on rides with any medical device or material.

Signed Print Name Date

APPLICATION FORM

Consent to Treatment

I, _____, parent/guardian of _____, hereby consent

to the medical/surgical treatment of _____. I acknowledge that my child has been given my full permission to undertake a trip under the care of Koru Care Otago Charitable Trust and understand the nature of the trip. I consent to my child receiving full medical treatment of any kind whilst in the care of Koru Care Otago and the administering of local or other anaesthetics for the purpose of such operation/s. I acknowledge that no assurance has been given that the treatment or operation will be performed by a particular surgeon or paediatrician. Should my child not be current with their vaccinations, I give permission in extreme circumstances, for them to be administered (i.e. tetanus). This consent was read over by me, the signatory, who acknowledges having understood it fully, and signed in the presence of a witness. I acknowledge that whilst every effort will be made to contact me, in an extreme situation that may not always be possible.

Signed _____ Print Name _____ Date _____

Witness Print Name Date

Checklist

Please read and ensure that you have done the following

- Answered all the questions
- Completed and signed all consent forms
- Read and understood what you have consented to
- Have included medical forms completed by GP, doctor or Specialist (whoever knows your child best)

Please note that the information you have provided will be used by Koru Care Otago only for the purpose of evaluating your child's suitability for a Koru Care Otago trip and to provide information to assist us to care for your child if they are accepted. This information will remain strictly confidential.

If you have any queries or concerns while completing this application, please contact us. Please do not send an incomplete application form, as it will be returned for completion, and delays may preclude eligibility for an upcoming trip.

Post the completed form to: Koru Care Otago Charitable Trust
68 Playfair Street, Caversham,
Dunedin 9012

OR Email korucareotago@gmail.com

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Declaration
The information I have provided on this form is correct and the medical forms attached have been given to my child's Doctor/Specialist for completion. I understand that if any information on this form is false, my child's application may be revoked. I understand also, that if my child is selected and travels with Koru Care Otago, they are to behave as an ambassador for Koru Care Otago. Any behaviour that jeopardizes the success of the trip may result in the child being sent home early (although only in extreme circumstances). I understand also that my child's eligibility for a Koru Care Otago trip will also be determined on Koru Care Otago attaining full medical/travel insurance and approval to fly from the airline. Signed_____ Print Name _____ Date _____

Please note: Applications close for 2025 on 20th June at 5pm

APPLICATION FORM

(To be completed by a doctor who knows your child's medical condition best (ie GP, Specialist, or Pediatrician)

Medical Assessment	**STRICTLY CONFIDENTIAL**
Child's Name:	Date of Birth:
History of Illness or Disability	
Medical Diagnosis:	Recent/Present treatment (surgery, chemo, DXR, physio)
Present Concerns or problems	Current Medications (including dosage, frequency, route)
Special Needs or Precautions	
Allergies: Blood Group: Medic Alert Bracelet: Yes □ No □ (if yes, please specify) Please tick Nebulizer: Oxygen: Litres/min: Continence Devices:	Additional Medications for trip: *(Antibiotics, Analgesia, Antihistamine, Nebulizers)* Urinary Catheter: Porta Cath/Central Line: Special Diet:
Additional Information	
Immunisation History Please Tick	Up to date □ Unknown □

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Infectious Disease exposure (dates and ages where applicable)

- □ Measles _____
- □ Rubella _____
- □ Mumps _____
- □ Chickenpox _____
- □ Covid 19 – Fully Vaccinated (including booster) Yes/No/Medically exempt

If medically exempt, please include documentation. If vaccinated, please forward Vaccine Record

Can this child go swimming?	Please tick	Yes □	No □
Can this child go on rough rollercoaster/motion master type rides?	Please tick	Yes □	No □
Can this child go on theme park rides (small and sedate)?	Please tick	Yes □	No □

System Overview

Head and Neck Hx of Head injury? Headaches?	**Cardiovascular** Hx of heart defects? Arrhythmia? Rheumatic fever?
Eyes, Ears, Nose and Throat Vision? Conjunctivitis? Hx of middle ear infection? Nose bleeds? Sore throats/thrush?	**Respiratory** Hx of respiratory distress? Hx of Asthma? Normal peak flow? Frequent Cough
Gastrointestinal Hx of GI defects? Diarrhoea/Constipation? Frequent stomach aches? Normal bowel pattern? Laxative/Enema use?	**Genitourinary** Hx of GU defects? Frequency/Pain/UTI's? Continent? Nocturnal enuresis? Menses?
Skin Rashes? Lesions? Hx of scabies/impetigo?	**Endocrine** Hx of jaundice/anemia? Bruise easily? Diabetic?
Neurologic Hx of seizures? Fainting/dizzy spells? Attention span? Development delay?	**Musculoskeletal** Hx of injuries/deformities? Co-ordination? Strength? Joint pain/ROM?

APPLICATION FORM

Other?
Please comment on Child's General Condition and Suitability
Declaration
The information given on this form is correct and I have included any reservations I may have regarding the participation of this child on a trip. Signed: Date: Name (please print): Telephone (0) Fax (0)