



PHYSICAL EXAMINATION FORM SIBLING

Please note that this a **nomination** form only and completion of this form does not guarantee that a child will be offered a place at camp. Please complete this form in printed English.

Please return to *European Family Liaison Department, Barretstown Castle, Ballymore Eustace, Co. Kildare, Ireland*

SIGN-OFF IS VALID FOR ONE YEAR FROM DATE OF SIGNING

PERSONAL DETAILS

Family Name:

First Name: Gender:

Date of Birth: Age:

Parents/Guardians Name:

Address:

Mobile Phone: Mobile Phone:

Email:

Has the child been to Barretstown before? Yes No If yes, what year(s)?

PATIENT CHILD DETAILS

Name of patient child Age (years)

Name of referring hospital:

RELEVANT MEDICAL DETAILS (e.g. appendix removed, tonsils removed, prone to ear infections, asthma, etc.)

SPECIAL NEEDS (Any special needs we should know about – behavioral, emotional, intellectual)

NAME, ADDRESS AND TELEPHONE NUMBER OF DOCTOR (GP)

Name:

Address:

Telephone number:

Parent/ legal guardian signature

Date

Typed or printed name