PHYSICAL EXAMINATION FORM

WL ACC

Please note that this a <u>nomination</u> 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: MALE / FEMALE

Date of Birth: DD/MM/YYYY Age:

Parents/Guardians Name:

Address:

Mobile Phone: Mobile Phone:

Email:

Type of camp that you are interested in:
☐ Spring Family ☐ Summer Camp ☐ Autumn Family ☐ Brother's and Sister's Camp

How many adults and children in the family? Adults _____ Children_____

MEDICAL DETAILS

Diagnosis:

Date of Diagnosis:

Relevant Medical History:

Date and type of last chemotherapy (if relevant):

SPECIALCARE

<u>Please tick the following special care if appropriate:</u>

Broviac/ Central line:	Yes ☐ No ☐	Wheelchair:	Yes ☐ No ☐	VP Shunt:	Yes ☐ No ☐
Port-a-Cath:	Yes ☐ No ☐	Crutches:	Yes ☐ No ☐	Seizures:	Yes ☐ No ☐
Peritoneal Dialysis Catheter:	Yes ☐ No ☐	Prosthesis:	Yes ☐ No ☐		
Haemodialysis Catheter:	Yes ☐ No ☐	Braces/Splints:	Yes ☐ No ☐	TPN:	Yes ☐ No ☐
Hearing Loss:	Yes ☐ No ☐	Gastrostomy Care:	Yes ☐ No ☐		
Vision Loss:	Yes ☐ No ☐	Nasogastric Care:	Yes ☐ No ☐	Skin Care:	Yes ☐ No ☐
Insulin Pump	Yes ☐ No ☐	Ostomy Care:	Yes ☐ No ☐	Physio:	Yes ☐ No ☐
Insulin Injection	Yes ☐ No ☐	Inhalation Therapy:	Yes ☐ No ☐		

SPECIAL CARE/TREATMENT CONTINUED:

If you have ticked yes to any of the special needs (above) or if the child requires any other special care or treatment while at camp, please give details below:

BEHAVIORAL ISSUES

Do you know of any behavioral issues, which could impact on the child's stay at Barretstown?
Yes □ No □ If yes, please advise:

ALLERGIES

Has the child any allergies? Yes □ No □

ALLERGIES	REACTION

CURRENT TREATMENT

NAME	ROUTE	DOSE	FREQUENCY

HOSPITAL INFORMATION

	DOCTOR	SOCIAL WORKER
NAME		
HOSPITAL		
ADDRESS		
ADDRESS		
ADDRESS		
PHONE NUMBER		
EMAIL ADDRESS		

Doctor's/Nurse Practitioner's Statement:

I have examined _____ and confirm that he/she is physically able to engage in all activities while at camp, except for any physical limitations and restrictions listed above.

_____ _____

Signature **Date** **Typed or printed name**

Hospital Stamp