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| Description: Description: Barretstown_SeriousFun_Email-Footer |  |  |
| **PHYSICAL EXAMINATION FORM** | **WL ACC** |

#### 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**

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| PERSONAL DETAILS  |
|  |
| Family Name:  MALE / FEMALEFirst Name: Gender:DD/MM/YYYYDate of Birth: Age:  |
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| Parents/Guardians Name:  |
|  |
| Address: Mobile Phone: Mobile Phone: Email:  |
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| MEDICAL DETAILS  |
| Diagnosis:Date of Diagnosis:Relevant Medical History: |
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| Date and type of last chemotherapy (if relevant): |
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| SPECIALCARE  |  |  |  |  |  |
| Please tick the following special care if appropriate:  |
| 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  |  |  |

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| 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: |

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| 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: |

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| ALLERGIES |
| Has the child any allergies? Yes No  |
| **ALLERGIES** | **REACTION** |
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| CURRENT TREATMENT  |
| **NAME** | **ROUTE** | **DOSE** | **FREQUENCY** |
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| 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.

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##### Signature Date Typed or printed name

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| **Hospital Stamp**  |