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| [Description: Description: Barretstown_SeriousFun_Email-Footer](http://www.barretstown.org/) |  |  |
| **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 / FEMALE  First Name: Gender:  DD/MM/YYYY  Date of Birth: Age: |
|  |
| Parents/Guardians Name: |
|  |
| Address:  Mobile Phone: Mobile Phone:  Email: |
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| MEDICAL DETAILS |
| Diagnosis:  Date of Diagnosis:  Relevant Medical History: |
|  |
| 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.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

##### Signature Date Typed or printed name

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| **Hospital Stamp** |