Barretstown
restoring young lives

PHYSICAL EXAMINATION FORM

Please note that this is a nomination form only and completion of this form does not guarantee that a child will be offered a place at camp. Form to be completed in printed English. Please return completed forms to; European Family Liaison Department, Barretstown Castle, Ballymore Eustace, Co. Kildare, Ireland or email to families@barretstown.org For all related queries please contact the team on +353 45863 130

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

PERSONAL

Family Name:

First Name:

Gender: MALE / FEMALE

Date of Birth: DD/MM/YYYY

Age:

Parents/Guardians Name:

Address:

Home Phone:

Mobile Phone:

***Email:**

Type of camp that you are interested in:

☐ Spring Family ☐ Summer Camp ☐ Autumn Family ☐ Brother's and Sister's Camp

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

MEDICAL DETAILS

Diagnosis:

Date of Diagnosis: DD/MM/YYYY

Relevant Medical History:

Date and type of last chemotherapy (if relevant): DD/MM/YYYY

SPECIAL CARE

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 ☐				
Vision Loss:	Yes ☐ No ☐	**Gastrostomy Care:**	Yes ☐ No ☐		
Insulin Pump	Yes ☐ No ☐	**Nasogastric Care:**	Yes ☐ No ☐	**Skin Care:**	Yes ☐ No ☐
Insulin Injection	Yes ☐ No ☐	**Ostomy Care:**	Yes ☐ No ☐	**Physio:**	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:		
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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PHYSICAL EXAMINATION FORM SIBLING

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PERSONAL DETAILS

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First Name: **Gender:** MALE / FEMALE

Date of Birth: DD/MM/YYYY **Age:**

Parents/Guardians Name:

Address:

Home Phone: **Mobile Phone:**

Email:

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)

Parent/ Legal Guardian Signature **Date** **Typed or Printed Name**