

APPLICATION FOR YOUNG PEOPLE WITH SPECIAL NEEDS TO TRAVEL TO LOURDES

updated June 2017

Items that must accompany this application:

- ☐ Part B: Medical Form, completed by doctor (with Universal Health Form and immunization record)
- ☐ Signed waiver
- ☐ Copy of passport – if applicant does not have a passport, check here ☐
- ☐ Copy of current medical insurance card, front and back
- ☐ Copy of IEP or 504 – if applicant does not have these education documents, check here ☐

Choose the ASCPG group to which you are applying (leave blank if you are unsure):

- ☐ Group 601 – Northern New Jersey
- ☐ Group 602 -- Rockland County, New York
- ☐ Group 605 – Western New Jersey
- ☐ Jet Set Group 606 -- adults who have traveled to Lourdes before as special needs pilgrims

Date _____ Name of person completing this application _____

Applicant's full name on birth certificate			
Nickname		Male or female	Date of birth
Has applicant traveled with ASCPG before?		If so, when?	
Address			
City		State	Zip
This address is <input type="checkbox"/> parents' home <input type="checkbox"/> mother's home <input type="checkbox"/> father's home <input type="checkbox"/> group home <input type="checkbox"/> guardian's home <input type="checkbox"/> medical facility <input type="checkbox"/> independent living facility <input type="checkbox"/> other			
Name of school		City	Is there an IEP or 504?
Name of training program		City	
Name of church		City	
Full medical diagnosis			Is applicant an adult AND his/her own guardian?

Does applicant have a passport?	Country of origin
Name as it appears on passport	
Expiration Date	Passport #

Does applicant have medical insurance?	Name of company
Policy #	Name of policy holder
Is there an anticipated change in insurance status or carrier between now and the trip?	

** attach copies of passport and front/back of medical insurance card **

Mother's name	Father's name
Address	Address
Home phone	Home phone
Cell phone	Cell phone
Email	Email
Best way to reach you	Best way to reach you
Occupation	Occupation

For new applicants, how did you hear about ASCPG? _____

t-shirt size _____ sweatshirt size _____ jacket size _____

List ALL doctors who regularly treat applicant	Address and phone number	Type of doctor
		PRIMARY CARE

REGARDING MEDICAL HISTORY, DOES THIS APPLICANT...	YES	NO
attend hospital regularly?		
have known allergies?		
If yes, list all:		
regularly take prescription medication?		
If yes, list:		
regularly take over the counter medication?		
If yes, list:		
use an inhaler?		
Last hospital stay:		
Anything else we should know?		
REGARDING TRAVEL, IS HE/SHE...	YES	NO
accustomed to being away from home -- if yes, with whom?		
accustomed to traveling by bus		
accustomed to traveling by airplane		
prone to motion sickness		
Anything else we should know?		
REGARDING MOBILITY, DOES HE/SHE...	YES	NO
walk independently		
use a wheelchair – if yes, explain		
walk with assistance (walker, crutches, cane, etc) – explain:		
Anything else we should know?		

REGARDING BEHAVIOR AND DISPOSITION, IS HE/SHE GENERALLY...	YES	NO
friendly		
happy		
nervous		
easily upset		
Excitable		
Hyperactive		
Inclined to wander		
shy		
Violent		
easily frustrated		
appropriate with members of the opposite sex		
prone to tantrums		
able and willing to follow directions		
Anything else we should know:		
REGARDING PERSONAL CARE, DOES HE/SHE NEED HELP WITH...	YES	NO
toileting		
washing		
Bedtime/sleeping		
dressing		
eating		
writing		
reading		
Incontinence -- if yes, is it during the day, night or both?		
Anything else we should know?		
REGARDING SPEECH AND HEARING...	YES	NO
Does he/she use hearing aids?		
Is his/her speech indistinct?		
Is he/she non-verbal?		
Does he/she communicate by sign?		
Does he/she use an electronic communication device?		
Does he/she read lips?		
Anything else we should know?		

Please share hobbies, interests, activities, etc:

Parent/Guardian Consent and Waiver

American Special Children's Pilgrimage Group (ASCPG) Easter Pilgrimage to Lourdes

Please read carefully, and initial each section to convey your understanding and agreement.

___ I/We understand that ASCPG needs a complete picture of the applicant to make an informed decision about his/her acceptance for the pilgrimage to Lourdes. I/We testify that all information in this application is true, and I/we have included all additional known information that pertains to this applicant.

___ If this applicant is accepted for the trip, I/We will continually provide updated information on his/her medical, mental and emotional condition to the Group Leader, Group Doctor and/or Group Nurse that could impact the care given to him/her on the trip. Furthermore, I/we will convey ALL information needed to care for this applicant to the volunteer helpers assigned to him/her.

___ I/We give permission to share medical information on an as-needed basis with the Group Doctor, Group Nurse, Group Leader and the applicant's volunteer helpers.

___ I/We understand that all people traveling as PILGRIMS have special medical and emotional needs and disabilities. At no time during the trip will they be without supervision by the Group Leader, Group Nurse and/or their helpers. From 10pm-7am, helpers will be supervise overnight hours.

___ I/We understand that just as if my family was on vacation in France, if a person requires medical attention above and beyond what ASCPG can provide (i.e., requires a visit to the hospital emergency room or hospital admission), he/she will be treated under the auspices of the French medical system. This means ASCPG will have no authority in the diagnosis or treatment process. However, ASCPG medical personal will remain with that person at all times, 24 hours a day, including overnight at a hospital or other medical facility. ASCPG medical personnel will also be in constant contact and consultation with the French local authorities, but final medical decisions will be made by those authorities.

___ I/We understand that by signing this consent, I/we waive ASCPG from any and all liability regarding any and all illness, accident or fatality arising from the applicant's trip to Lourdes.

___ If this applicant is accepted for the pilgrimage to Lourdes (check one):

- ☐ I /We DO give permission for his/her photo and image to be used for publicity purposes (this includes ASCPG brochures, the ASCPG website and ASCPG-run social media accounts)
- ☐ I/We DO NOT give permission for his/her photo and image to be used by ASCPG.

By signing this consent, I/we acknowledge that I/we fully comprehend the above.

Applicant's Full Name		
PRINT Parent(s)/Guardian(s) name		Date
SIGN Parent(s)/Guardian(s) name		Date
SIGN if applicant is his/her own guardian		Date

American Special Children's Pilgrimage Group

PO Box 633, Bergenfield NJ 07621 * 201-873-8054 * www.ascpg-lourdes.org

Part B (2 pages): This must be completed by the applicant's primary medical doctor revised 6/17

Name of Patient _____ Date of Birth _____

Because this patient is applying to travel to Lourdes, France, during Easter Week, our ASCPG medical team is requesting the following information. Confidentiality will be respected. Thank you so much.

Doctor's name

Primary diagnosis	Height
Secondary diagnosis	Weight
Drug/Allergy sensitivity	Has he/she had <input type="checkbox"/> Measles <input type="checkbox"/> Chicken pox
Significant past medical history	
Significant past surgical history	Date of last tetanus shot:
Is there surgery planned?	

- ☐ I am attaching an up-to-date immunization record
- ☐ I am attaching a recent Universal Health Form

MEDICATIONS	SCHEDULE AND DOSE	HOW ADMINISTERED	REASON PRESCRIBED	POSSIBLE SIDE EFFECTS

Does he/she require special medical equipment? Explain:

To what extend is this applicant affected with...	NONE	MILD	MODERATE	SEVERE
Physical disability				
Mental disability				
Sight impairment				
Hearing impairment				
Speech impairment				
Seizures if YES, check: <input type="checkbox"/> convulsions <input type="checkbox"/> petit mal <div style="margin-left: 150px;"><input type="checkbox"/> grand mal <input type="checkbox"/> partial</div> <div style="margin-left: 150px;"><input type="checkbox"/> myoclonus <input type="checkbox"/> other</div> When was the last one? How frequent are seizures?				
Hyperactivity				
Nervousness				
OCD				
Depression				
Diabetes				
Heart condition				
Compromised immune system				
Neural tube defect				
Cystic Fibrosis				
Epilepsy				
Neurological disorder				
Psychiatric disorder				
Psychosis				
Please explain any of the above:				

Please check and explain IF you:

- ☐ have concerns about the 20+ hour journey (each way, flights and bus)
- ☐ have advice for ASCPG's medical team and volunteer caregivers
- ☐ want an ASCPG doctor to contact you (with the applicant's permission)

Name (print)	Stamp
Signature Date	
Best number to contact you	
Address	

Thank you!