American Special Children's Pilgrimage Group
PO Box 633, Bergenfield NJ 07621 * www.ascpg-lourdes.org

APPLICATION FOR YOUNG PEOPLE WITH SPECIAL NEEDS TO TRAVEL TO LOURDES

updated 7/22

IMPORTANT: These items must accompany this application:

- ☐ Part B: Medical Form, completed by doctor (with Universal Health Form and immunization record)
- ☐ Copy of passport – if applicant does not have a passport, check here []
- ☐ Copy of current medical insurance card, front and back
- ☐ Copy of Covid-19 immunization card
- ☐ Copy of IEP or 504 – if he/she does not have these educational documents, check here []

Date_____ Who is completing this application?_____

About the applicant

Full name	Circle: Male / Female
Nickname	Date of birth
Has he/she traveled with ASCPG before?	If YES, when?
If you are new to ASCPG, how did you hear about the trip?	
Address/City/State/Zip This is the home of []parents []mother []father []guardian []self []other_____ OR a []group home []medical facility []independent living facility	
School or training facility	City
Church	Size: tshirt sweatshirt jacket
Is he/she an adult AND his/her own guardian?	
Activites, interests, hobbies	

Does the applicant have a passport?	Country
Name as it appears on passport	
Expiration date	Passport #

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

Mother:	Father:
Address	Address
Phone	Phone
Email	Email
Occupation	Occupation

Pertinent Personal and Medical Information

Full Diagnosis

List ALL doctors who regularly treat applicant	Address and Phone	Type
		PRIMARY CARE

Covid-19 Vaccine Status – All travelers must be fully vaccinated (initial dose + one booster).
Please check one:

- ☐ This applicant is fully vaccinated
- ☐ This applicant is not fully vaccinated – explain:

ALL prescription + over the counter medication	Dosage	Reason

MEDICAL HISTORY – DOES HE/SHE…	**NO**	**YES – EXPLAIN**
attend hospital regularly?		
Last hospital stay:		
have known allergies?		list all:
use an inhaler?		
Is there anything else we should know?		
TRAVEL – IS HE/SHE…	**NO**	**YES – EXPLAIN**
accustomed to being away from home?		with whom?
accustomed to traveling by bus?		
accustomed to traveling by airplane?		
prone to motion sickness?		
Is there anything else we should know?		
MOBILITY – DOES HE/SHE...	**NO**	**YES – EXPLAIN**
walk independently?		
use a wheelchair?		
walk with aid (crutches, cane, walker, etc)?		
Is there anything else we should know?		
SPEECH + HEARING – DOES HE/SHE…	**NO**	**YES – EXPLAIN**
use hearing aids?		
have indistinct speech?		

Is he/she non-verbal?		
communicate by sign?		
use an electronic communication device?		
read lips?		
Is there anything else we should know?		

BEHAVIOR + DISPOSITION: IS HE/SHE GENERALLY…	**NO**	**YES – EXPLAIN**
happy?		
friendly?		
nervous?		
easily upset?		
excitable?		
hyperactive?		
anxious?		
inclined to wander?		
shy?		
violent?		
easily frustrated?		
appropriate with people of the opposite sex?		
prone to tantrums?		
willing and able to follow directions?		
Is there anything else we should know?		
PERSONAL CARE: IS HELP NEED WITH...	**NO**	**YES – EXPLAIN**
toileting?		
washing?		

bedtime/sleeping?		
dressing?		
eating?		
writing?		
reading?		
incontinence?		Day, night or both?
Is there anything else we should know?		

Parent/Guardian Consent and Waiver – ASCPG Pilgrimage

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, ASCPG helpers and volunteers will 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 personnel 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 <u>do</u> 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 <u>do not</u> give permission for his/her photo and image to be used by ASCPG.

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

Applicant's full name	
Parent #1 Name (print)	
Parent #1 Signature	Date
Parent #2 Name (print)	
Parent #2 Signature	Date
Guardian Name (print)	
Guardian Signature	Date
Applicant Signature, <u>only</u> if he/she is his/her own guardian:	Date

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Part B – 2 pages, to be completed by PRIMARY MEDICAL DOCTOR (rev 7/22)

Dear Doctor: *Because this patient is applying to travel to France during Easter Week, our ASCPG medical team is requesting the following information. Confidentiality will be respected. Thank you very much!*

DOCTOR'S NAME (Print)_____

Name of Patient	Date of Birth
Primary diagnosis	Height
Secondary diagnosis	Weight
Drug/Allergy sensitivity	
Has he/she had: []measles []chicken pox []covid-19	Date of last tetanus shot
Is their surgery planned?	
Significant past surgical history	
Significant past medical history	
Is there a history of seizures? []NO []YES – please check: [] convulsions [] petit mal [] partial [] grand mal [] myoclonus [] other When was the last one? How frequent are seizures?	
Special medical equipment required? []NO []YES – explain	
I am attaching the following: [] up-to-date immunization record [] recent Universal Health Form	

MEDICATION	Schedule & Dose	How Administered	Reason Prescribed	Possible Side Effects

Indicate Level of Severity	None	Mild	Moderate	Severe	EXPLAIN
Physical disability					
Mental Disability					
Sight impairment					
Hearing impairment					
Speech impairment					
Hyperactivity					
Nervousness					
OCD					
Depression					
Diabetes					
Heart condition					
Compromised immune system					
Neural tube defect					
Cystic Fibrosis					
Epilepsy					
Neurological disorder					
Psychiatric disorder					
Psychosis					

Please check IF you:

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

Signature	Date
Address	Stamp:
Best number to contact you	