

SECTION 1: PERSONAL DETAILS (PLEASE ANSWER ALL QUESTIONS)

Personal Details:

Forename:

Last Name:

Date of Birth: (DD/MM/YY):

Correspondence Address:

Post Code:

Preferred phone number:

Other Phone Number:

Email Address:

Weight:

Height:

Next of Kin:

Forename:

Last Name:

Relationship:

Address:

Post Code:

Phone:

Mobile:

Email Address:

Contact Details of person who will collect you at the end of the holiday:

Forename:

Last Name:

Relationship:

Address:

Post Code:

Phone:

Mobile:

Email Address:

Your Doctor's Details

Forename:

Last Name:

Full Address:

Postcode:

Telephone number:

Passport and Healthcard (this is required for all European travel)

Passport No:

Date of Expiry:

EHI Card No:

Date of Expiry:

Insurance provided by Jumbulance Trust at a cost of £48 per person* (separate cheque is required for this)

*If you have your own insurance please provide details below

Insurance Provider : Policy No :

SECTION 2: MEDICAL INFORMATION

IF YOU HAVE A CARE PLAN PLEASE PROVIDE A COPY

Medical Condition(s):

Past Operations:

Are you a diabetic YES/NO

If yes, how is this controlled:

Have you a pacemaker: YES/NO

Do you suffer from epilepsy? YES/NO

If yes, how is this controlled:

When was your last attack?:

Do you suffer with dementia?

Please specify other medical conditions requiring injections or special treatment below:

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Mobility:

Specify aids used i.e. walking sticks, zimmer frame etc

Are you able to stand? YES/NO

Are you able to walk? YES/NO

Are you able to manage stairs? YES/NO

Do you use a wheelchair? YES NO

Do you have your own wheelchair? YES/NO

If yes, is it collapsible? YES/NO

Do you need a hoist for transferring? YES/NO

Wheelchair Dimensions & Weight

Width Open Height Open Depth Open

Width Folded Height Folded Depth Folded

Weight : kg

Communication

Sight: NORMAL/RESTRICTED*/BLIND/GLASSES/CONTACT LENS
Hearing: NORMAL/RESTRICTED*/HEARING AID
Speech: NORMAL/RESTRICTED*
Please specify restriction and aids used e.g. boards, cards etc

Breathing

Do you use inhalers? YES/NO
(if yes, please bring your own)
Do you use a Nebuliser? YES/NO
(if yes, please bring your own)
Do you need oxygen? YES/NO
(if used frequently please bring your own supply which must be ordered in advance)

Personal Hygiene

Independent with personal care? YES/NO
Do you need assistance with washing? YES/NO
Do you need assistance with dressing? YES/NO
Are you continent/incontinent?
Do you use pads? YES/NO
(if yes please bring your own)
Do you have a catheter? YES/NO
(If yes, date last changed and bring spare)
Do you self-catheterise? YES/NO
(Please bring extra supplies)
Do you use any of the following:
Bottle (if yes please bring your own) YES/NO
Bedpan YES/NO
Commode YES/NO
Any current sore areas or wounds YES/NO
Treatment given:
(please bring 10 days' supply of dressings)

Nutrition

Please state any special diet:
Do you need assistance with feeding? YES/NO
Do you need assistance with drinking: YES/NO
Are any aids or appliances used? YES/NO
(please bring special cups, straw, rimmed plate etc)
Are you fed by a gastic tube? YES/NO
(Please bring at least 10 days supply)

Night Time

Do you need any help during the night? YES/NO

Allergies

Any known allergies? YES/NO

Any known drug sensitivities? YES/NO

Medication

Are you self-medicating? YES/NO Please list ALL medication and attach Chemist's print out
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Any other information which may be relevant:
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**IMPORTANT – PLEASE BRING 10 DAYS SUPPLY OF MEDICATION AND DRESSINGS WITH YOU.
If any of the above medication information should change before the date of travel please inform your group leader as soon as possible.**

SECTION 3: GENERAL INFORMATION

Are you a smoker? YES/NO

The Jumbulance Trust has a strict no smoking policy on the vehicles

Is this your first Jumbulance Trip? YES/NO

Can we use photos and footage of you? YES/NO

I confirm that the above information is correct and authorise the Jumbulance Trust or its representatives to seek confirmation from my Doctor if required. For insurance purposes I also confirm:

- i) That I am not travelling against the advice of a medical practitioner nor for the purpose of obtaining medical treatment abroad.
- ii) That I am not expecting to give birth before or within eight weeks following the date of arriving home (ladies)

Application's Signature:

Date:

WHEN COMPLETED PLEASE RETURN TO GROUP ORGANISER