

Date of Application: ____ / ____ / ____.



PARADISE KIDS ILLNESS SUPPORT HOLIDAY APPLICATION FORM

Name of Referring Organisation: _____

Address: _____

Postcode: _____

Contact Person: _____ Position: _____

Email: _____ Phone: _____

FAMILY DETAILS

Family Name: _____ Child's Name: _____

Child's Illness: _____

Boy Girl Child's Age: _____ child resides with: _____

Is the child aware of the nature their illness? Y N Wheelchair? Y N

Does the child have any communication difficulties? Y N yes? details: _____

Mother's Name: _____ Legal Guardian: Y

Address: _____

Postcode: _____

Email: _____ Phone: _____

Father's Name: _____ Legal Guardian: Y

Address: _____

Postcode: _____

Email: _____ Phone: _____

APPLICATION CONTINUED...



Please provide a brief history of the family and the reason for the referral:

CHILD'S SIBLINGS

Other Children in the Immediate Family attending the program:

Child's Name: _____ Relationship: _____ Age: _____

Child's Name: _____ Relationship: _____ Age: _____

Child's Name: _____ Relationship: _____ Age: _____

Does anyone in the family have special needs or a disability? Y N yes? details:

Does anyone in the family have a mental illness? Y N yes? details: _____

Is the family currently receiving services from the dept of Child Protection? Y N

yes? details: _____

Family Doctor's / Specialist Name: _____

Address: _____

Postcode: _____

Email: _____ Phone: _____

All information remains strictly confidential and is only used to access family's suitability for the program. Please ensure child's illness will pass medical clearance for air travel (if applicable) before referring them for our program.

Please return this form to:

Email: paradisekids@wmq.org.au | Phone: (07) 5625 1900

Visit: 88 Allied Drive, Arundel 4214 | Post: PO Box 1290, Runaway Bay QLD 4216