Childspring International Treatment Application

Welcome to Childspring International!

We are pleased you have found our organization and request our assistance to provide access to medical care for your child.

Childspring International is a globally-focused nonprofit based in the United States that provides life-changing surgeries for children from developing countries, and as a result transforms communities. Since our inception, we have treated over 4,000 children from 52 countries with a variety of conditions that are treatable with access to surgical care.

Included here is our treatment application. The purpose of this application is for Childspring to learn a little more about the child seeking treatment and to see whether our organization is well positioned to find and secure for the child quality treatment. While we cannot serve all children, we hope that this application is a way for us to learn more about the children requesting assistance and to find ways that we may be able to help them secure access to medical treatment.

Once you complete and submit your application, the child's case will be reviewed first by our staff and then by our medical committee. Sometimes, the medical committee may request additional information, like an x-ray of an affected area, in order to make a fully informed determination of the case. Once all information is obtained, the committee will then make a determination as to whether Childspring can proceed with supporting the case.

Childspring typically serves children under 18 years of age with conditions that can be treated with a single surgery. Historically, Childspring has served cased in the areas of orthopedics, prosthetics, angiology (vascular), cardiology, ophthalmology, plastics, gastroenterology, urology, neurology, otorhinolaryngology (ear, nose, & throat), and general surgery cases. Each case is evaluated individually, and we cannot guarantee treatment for all children.

Our Medical Committee only accepts children who can be treated before their 18th birthday and who require only one or a maximum of two surgeries. . Typically, we cannot serve children living with chronic conditions like spina bifida, hydrocephalus, diabetes, cerebral palsy, cystic fibrosis, Down syndrome, epilepsy, muscular dystrophy, and cancer. In addition, our organization does not provide organ transplants. If Childspring's Medical Committee accepts the child's case, Childspring staff will search up to 12 months for a doctor and hospital to provide the necessary treatment.

If an acceptable treatment location and plan is secured within 12 months, Childspring will work to:

- Provide specific medical treatment as specified at no cost to the child or family

- Prepare proper documentation to apply for the child's visa and travel
- Support roundtrip transportation for the child to the treatment location,
- Make arrangements for a volunteer host family for the child to live with while in the United States. (for United States cases only)
- Provide regular updates on the social and medical progress of the child, and

Ensure the child is returned safely back to you transformed and ready for their new life. Childspring staff will be your source of communication before, during and after your child receives treatment. If a treatment location is not found within 12 months, Childspring will close the case.

As you evaluate whether Childspring is the organization to help your child, please note the following:

- Childspring is not an adoption agency and adoption is strictly against our policies. The child will return to their home country of origin after medical treatment is completed.
- Childspring does not permit a parent, family members, or friends to travel to the United States with the child.
- Childspring does not permit family members or friends already in the United States to have contact with your child.
- We do not encourage long-term relationships with our volunteers in the United States
- Childspring is a nonprofit that focuses specifically on providing surgeries to children in need, and therefore cannot provide families and caregivers with any financial support not directly related to the child's medical treatment.

Please carefully review each of the required documents that must be completed in order for Childspring to consider a case. By signing below and submitting this application you agree to follow the policies and guidelines set by Childspring.

If you have applied to multiple organizations and decide not to work with Childspring, please, let us know and we will stop pursuing options for your child.

If you have any questions feel free to contact me by phone at 404-228-7773 or by email at

Thank you,

Drew Reynolds, PhD, MSW, MEd
Program Director
Childspring International

INSTRUCTIONS FOR APPLICATION FOR TREATMENT

Please include the following documents with your application to Childspring International. In most cases, the following will be needed in order to successfully present your case to our medical committee.

Please note that all documents are reviewed in English. If you have documents are not prepared in English, please provide a translation so that we can adequately review your case. **Please print clearly.**

1. **Point of Contact** in child's country with complete contact information. (see below)
2. Childspring International **Application for Treatment** – six-page form.
3. **Complete medical report** from the child's primary doctor. Include an accurate diagnosis, details of the onset of the condition, and medical records so the Childspring doctors can thoroughly evaluate the case and decide a course of treatment. Please note that none of these documents, lab results, x-rays, etc. will be returned.
4. A recent **full body picture** of the child.
5. Several **pictures of area to be treated** as specified in the application.
6. Heart patients must include: Chest X-Rays and Echocardiogram less than 3 months old.
7. **Doctor's Release Letter** printed on child's primary doctor's letterhead and signed.
8. **Photo Release**

When possible, Childspring also requests that the following documents be included in the application:

1. A copy of the child's Birth Certificate.
2. A copy of the child's passport photo and data page.

Please note that submitting an application does not guarantee treatment. Paper records sent will not be returned.

To submit your application, you may scan this form and email it to drew@childspringintl.org, fax it to 404-228-7759, or send a hard copy to the following address:

Drew Reynolds, PhD, MSW, Med
Childspring International
1328 Peachtree Street NE
Atlanta, GA 30309

Case referred by

Name _____

Email _____

Address _____

_____

Child's Point of Contact

Name _____

Email _____

Address _____

_____

EXPLANATION OF APPLICATION FORM

Past History

- **Information related to mother's pregnancy and newborn:** More emphasis will be placed on this information especially when it pertains to an infant patient. The information in this section could include:
  - Hospital, city of delivery.
  - Pregnancy – Age of mother, length of gestation, exposure to infectious diseases, use of medications, drugs, alcohol and/or tobacco.
  - Type of delivery and presentation (vertex or breech), weight and length of newborn, Apgar score.
  - Complications of newborn – Hypoglycemia, cyanosis, pallor, seizures, jaundice, skin lesions, muscle skeletal deformities, respiratory distress or feeding problems.
- **Previous Illnesses and Surgeries:**
  - Serious childhood illnesses – date and severity/complications.
  - Surgical procedures – Approximate dates, tests performed pre-operatively, and complications.
  - Injuries and fractures
- **Medication and Allergies:**
  - Current Medications: Include name of medication, dose, frequency and reason for the medication.
  - List all known allergies.
- **Habits, Personality and Favorite Activities**:
  - Household chores, contribution to family life
  - Ways interacts with others – friends, family, community
  - Hobbies
  - Issues with regard to sleep or behavior
- **Family/Genetic History:** Record all known significant diseases in first-degree relatives (parents, grandparents, aunts, uncles and siblings). Record all deaths in these same first-degree relatives. Examples might include diabetes, cancer, epilepsy, allergies, hereditary blood disorder, early coronary artery disease, high cholesterol, mental retardation, muscular dystrophies, congenital anomalies, degenerative diseases, cystic fibrosis and celiac disease.
- **Immunizations:** Indicate sources of information, dates immunizations given, and which immunization was provided.

Social History

- Living circumstances: place and nature of dwelling, sleeping arrangements, caregiver.
- Economic circumstances.
- Parents occupations and marital status.
- Household pets.
- Potential exposures to toxins in home, for example, cigarette smoke exposure.
- Age of home if children less than 3 years of age (possible lead exposure)
- Water source

Answer all questions as clearly and thoroughly as possible.

Clinical Evaluation

Physical Evaluation & Assessment

History of Primary Diagnosis

Information in this section is of great importance. The details included here should be written concisely and orderly. List all the pertinent, positive and negative background. The information should be listed chronologically; list the initial symptom, then the subsequent symptoms. The portions of Past History related to the present illness should be included here.

Childspring International
Application for Treatment

Dear Parent/Caregiver,
Please complete this questionnaire about your child to the best of your ability. Include all known details whether or not they seem applicable to the child's current primary diagnosis. This will help our evaluation. Thank you.

Patient's Full Name:			
Sex:		Date of Birth:	
Complete Address:			
Phone Number(s):			
Primary Caregiver(s):			
Primary Diagnosis::		Explain in detail.	
Secondary Diagnosis:			
Explain history of Primary Diagnosis.			
List ALL issues the mother had during pregnancy.			
List ALL issues experienced by the child at birth or during the first few months.			
List ALL the child's previous illnesses and date of occurrence.			
List ALL the child's previous surgeries (diagnosis, surgery performed, etc.) and date of occurrence.			

List ALL medications the child takes on a regular basis.	
List ALL the child's allergies.	Allergies to medicine: Environmental allergies:
Explain the child's habits, personality and favorite activities.	
List ALL family genetic history.	
List the child's immunization history.	List individual immunizations/date received or attach Immunization Record. Include HIV, TB and Hepatitis.
Is post-operative care available in the child's home country? □ Yes □ No	Explain:

Social History

1. Does the child attend school? □ Yes □ No

   - If **yes**, please provide the following information:
     Name of school: _____
     Location: _____
     Grade Level: _____
   - If **no**, does the child's condition interfere with attendance at school? Explain.

     _____

     _____

2. Describe the child's living arrangements: place and nature of dwelling, sleeping arrangements, caregiver, and financial circumstances and surrounding environment.

   _____

   _____

3. Describe the child's personal relationships with family, friends and community. How are they treated due to their medical condition?

   _____

   _____

Clinical Information

1. Is the child about the correct size for his/her age? □ Yes □ No
   If **no**, check all that apply:
   □ Underweight □ Shorter than average □ Difficulty gaining weight
   □ Overweight □ Taller than average □ Recently gained/lost a lot of weight

2. Does the child eat a normal amount? □ Yes □ No

3. What does the child's diet consists of?

   _____

   _____

   _____

4. Please check the activities which the child cannot do WITHOUT HELP:
   □ Use spoon/fork to eat □ Crawl on hands and knee □ Hold own bottle
   □ Drink from cup □ Scoot across room on stomach □ Finger feed self
   □ Toilet trained (daytime) □ Pull up to standing position on own □ Hold own cup
   □ Toilet trained (night) □ Walk holding on □ Use rest room
   □ Sit alone □ Walk independently □ Dress self
   □ Roll over □ Run as fast as other children □ Assist with dressing
   □ Climb up/down stairs □ Get up on hands and knees □ Undress self
   □ Get into sitting position □ Rise from chair to standing position □ **NONE**

5. Does the child have:
   □ Difficulty sucking □ Difficulty chewing □ Diarrhea □ Constipation
   □ Difficulty swallowing □ Choking problems □ Tube feedings □ **NONE**
   Other digestive problems: _____

6. Check the items which best describe the child:
   □ Looks when name is called □ Counts □ Uses sentences of 2-3 words
   □ Knows colors □ Says 3-4 words □ Responds to requests
   □ Turns pages in book □ Reads □ **NONE**

7. Is the child able to communicate his/her needs? □ Yes □ No
   If **yes**, check all that apply:
   □ Uses words, speech □ Uses communication device □ Uses sign language
   Other: _____

8. Does the child have a vision problem? □ Yes □ No
   Describe: _____

9. Does the child have a hearing problem? □ Yes □ No
   Describe: _____

10. Does the child receive services/therapies?
    □ Physical Therapy □ Occupational Therapy □ Speech Therapy
    Other: _____

11. Does the child use any special equipment?
    □ Braces (orthoses) □ Prosthesis □ Crutches □ Walker □ Wheelchair
    Other: _____

12. Does the child use tobacco/smoke? □ Yes □ No

13. Does the child have any other medical problems? □ Yes □ No
    If **yes**, explain: _____

Physical Evaluation and Assessment

1. Restate the child's Primary Diagnosis as listed on Page 1: _____
   _____

2. Has the child been evaluated by a doctor? □ Yes □ No
   If **yes**, what is the doctor's specialty? _____

3. Is the injury due to trauma or was the child born with it? □ Trauma □ Born with it
   If **trauma**, list date and explain event in detail: _____
   _____

4. Does the child appear to be in pain? □ Yes □ No

5. Does the pain affect the child's ability to function? □ Yes □ No

6. Is the child able to function normally besides the injury/deformity/complaint? □ Yes □ No

7. Does the child have scars? □ Yes □ No
   If **yes**, are the scars the result of birth deformity, injury or prior surgery? Explain in detail.
   _____

Primary Diagnosis

If child's PRIMARY DIAGNOSIS relates to:

1. **SHOULDERS, ARMS, HANDS, HIPS, LEGS AND/OR FEET**, answer **A.** on page 9.
2. **FACIAL DEFORMITIES**, answer **B.** on page 9.
3. **EYES**, answer **C.** on page 9.
4. **CHEST**, answer **D.** on page 9.
5. **BACK**, answer **E.** on page 9.
6. **TUMOR OR MASS**, answer **F.** on page 9.

By signing below, I hereby certify that all information provided on this application is true and correct to the best of my knowledge. I understand that false information can disqualify me from services provided by Childspring International.

This information completed by: _____ Date: _____

Relationship to child: _____

Questions About Child's PRIMARY DIAGNOSIS

A. Answer questions below if child's PRIMARY DIAGNOSIS relates to SHOULDERS, ARMS, HANDS, HIPS, LEGS AND/OR FEET:

- Does the child have normal sensation? □ Yes □ No
  - + Can they feel vibration? □ Yes □ No
  - + Can they feel light touch? □ Yes □ No
  - + Can they feel deep touch? □ Yes □ No
- Can the child move *above mentioned areas* in all directions? □ Yes □ No
  If **yes**, is it painful to move in all directions? □ Yes □ No
- If problem with <u>shoulders/arms/hands</u>, remove shirt. **Take video** while child:
  □ rotates extended arm in circle □ flexes elbow/hands
- If problem with <u>legs/feet</u> remove shoes/socks and roll up pants to expose Primary Diagnosis. If problem with <u>hips</u> remove pants. **Take video** while child: □ standing up □ walks toward camera □ away from camera □ on toes □ on heels □ squatting down

B. Answer questions below if child's Primary Diagnosis relates to FACIAL DEFORMITIES:

- Is there redness or swelling at the site? □ Yes □ No
- Is it painful when touched? □ Yes □ No
- Is it painful when not touched? □ Yes □ No
- Does the child have normal sensation? □ Yes □ No
  - + Can they feel vibration? □ Yes □ No
  - + Can they feel light touch? □ Yes □ No
  - + Can they feel deep touch? □ Yes □ No
- Take three pictures: □ Squeezing Face □ Clenching jaw □ Sticking out tongue

C. Answer questions below if child's Primary Diagnosis relates to EYES:

- Can the child follow finger movement? □ Yes □ No
- Are pupils dilated or constricted? □ Dilated □ Constricted
- Do the pupils respond to light in the same way? □ Yes □ No
  If **no**, explain*:* _____
- Take two pictures: □ Opening eyes as wide as possible □ Closing eyes tightly

D. Answer questions below if child's Primary Diagnosis relates to CHEST:

- Does child have difficulty breathing while performing normal, daily activities? □ Yes□ No
- Does the collarbone feel like it is popping or crunching? □ Yes □ No
  If **yes**, explain: _____
- Is the collarbone even on both sides? □ Yes □ No
  If **no**, explain: _____

E. Answer questions below if child's Primary Diagnosis relates to BACK:

- Have child remove shirt. Take four pictures:
  □ Bending over w/ hands touching ground □ Standing up as straight as possible
  □ From side w/hands straight down side □ From front w/hands straight down by side

F. Answer questions below if child's Primary Diagnosis relates to TUMOR OR MASS:

- Is there redness or swelling surrounding it? □ Yes □ No
- Has the mass grown in size? □ Yes □ No
  If **yes**, how quickly? Include general time period. _____
- When did it first start to develop? _____
- Does it have a pulse? □ Yes □ No
- Is their bruising surrounding it? □ Yes □ No
- Is it painful to touch? □ Yes □ No
  If **yes**, explain: _____

CHILDSPRING INTERNATIONAL
PHOTO AND VIDEO RELEASE FOR MINOR CHILD OR CHILDREN

I hereby authorize Childspring International to publish photographs taken of myself and/or the minor child or children listed below, and our names and likenesses, for use in Childspring International's print, online and video-based marketing materials, as well as other Childspring International publications and at fundraising events.

I hereby release and hold harmless Childspring International from any reasonable expectation of privacy or confidentiality for myself and for the minor child or children listed below associated with the images specified above. I understand that Childspring International works to protect the dignity and privacy of the children they serve, and will not release sensitive medical information.

Further, I attest that I am the parent or legal guardian of the child or children listed below and that I have full authority to consent and authorize Childspring International to use their likenesses and names. I further acknowledge that participation is voluntary and that neither I, the minor child, nor minor children will receive financial compensation of any type associated with the taking or publication of these photographs in Childspring International publications (print, online, video-based materials) or at fundraising events. I acknowledge and agree that publication of said photos confers no rights of ownership or royalties whatsoever.

I hereby release Childspring International, its contractors, its employees and any third parties involved in the creation or publication of Childspring International publications (print, online, video-based materials), from liability for any claims by me or any third party in connection with my participation or the participation of the minor children listed below.

Authorization –
Printed Name: _____

Signature: _____ Date: _____

Address: _____

Relationship to Children: _____

Names and Ages of Minor Children –
Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

------ TRANSLATOR AFFIDAVIT ------

I, _____, hereby certify and attest that I am fluent in both reading and speaking English and the _____ language, which is understood by the parent(s) and/or legal guardian(s) of the Child who signed this document. I certify that I have read this entire document to them in their native language, in a manner such that the parent(s) or legal guardian(s) of the Child understood the entire document before signing it. I further certify that I have accurately translated the conversations, the questions, and the answers that occurred in my presence between the Child, the parent(s), or legal guardian(s) of the Child, and representatives of Childspring International prior to this document being signed.

So certified and attested by me as translator, on this _____day of _____, 201__

Signature of Translator: _____

Printed Name: _____