

Welcome to Childspring International!



We are pleased you have found our organization and request our assistance to treat your child. In order to best serve your child, Childspring has developed policies, guidelines and expectations for you, Childspring staff, and our many volunteers. It is important you review and understand these principles, particularly our scope of care, before you submit an Application for Treatment to Childspring. By submitting a completed Application for Treatment you indicate you understand and will abide by all practices of Childspring International.

As the parent or legal guardian of the child, it is your responsibility to supply all the information that Childspring requests in a timely manner. Whether an X-ray, MRI, passport, immunization or medical records, it is the parents' responsibility to provide these documents. Please fill out the following six-page form to the best of your ability. The more information you share regarding your child's condition, the better our physicians can determine the best course of treatment. The parent(s) must also confirm if necessary aftercare is available in the country of origin and will be funded by the child's family.

Once Childspring receives a completed application with medical records, you can expect the case will be presented to our Medical Committee fairly and completely. Our Medical Committee will not accept children who cannot be treated before their 18th birthday, require more than two surgeries or have a chronic condition. Thus, conditions like Spina Bifida, hydrocephalus, diabetes, Cerebral Palsy, cystic fibrosis, Down syndrome, epilepsy, muscular dystrophy, cancer and organ transplants will not be accepted into our program. Treatments/surgeries that typically fall within Childspring's scope of care include most all orthopedics, prosthetics, gastrointestinal, cardiac (ASD, PDA, VSD, TOF), removal of benign tumors, plastics, strabismus, and urology. If Childspring's Medical Committee accepts your child's case, Childspring staff will search up to 12 months for a doctor and hospital to provide the necessary treatment.

If a treatment location is found within 12 months, Childspring will provide:

- a. Treatment as specified,
- b. Proper documentation to apply for the child's visa,
- c. Roundtrip airline ticket for the child to the treatment location,
- d. Volunteer host family for the child to live with while in the U.S.
- e. Regular updates, and
- f. Return the child back to you transformed and ready for his or her new life!

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. Your child will return to you after medical treatment is completed.
- Childspring does not permit a parent, family members, or friends to travel to the USA with the child.
- Childspring does not permit family members or friends already in the USA to have contact with your child.
- We do not encourage long-term relationships with our volunteers in the USA.
- Childspring is not a funding source for your family's needs. We are only able to offer medical treatment for children. Please do not ask our wonderful volunteers for money to dig wells, buy homes, or fund business ventures.

Childspring staff will be your source of communication before, during and after your child receives 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 susan@childspringintl.org.

Thank you,



Susan H. Wanserski
Program Director
Childspring International



INSTRUCTIONS FOR “APPLICATION FOR TREATMENT”

The entire application must be carefully read, fully understood,
signed and promptly returned to:

Susan H Wanserski, Program Director
Childspring International
1328 Peachtree Street NE
Atlanta, GA 30309
susan@childspringintl.org
Tel: 404-228-7773 Fax: 404-228-7759

The following documents must be fully completed **IN ENGLISH** for Childspring International to consider a case. Please **PRINT CLEARLY**.

1. Point of Contact in child’s country with complete contact information.
2. 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.
3. A copy of the child’s Birth Certificate.
4. A recent full body picture of the child.
5. Several different 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. A copy of the child’s passport photo and data page.
9. Childspring International Application for Treatment – six-page form.
10. Photo Release

Only Applications completed CLEARLY AND IN ENGLISH will be considered! Submitting an Application does not guarantee treatment. Records will not be returned.

Case Referred By (name and contact information):

Point of Contact in Country (name and contact information):



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 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? <input type="checkbox"/> Yes <input type="checkbox"/> 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 can to 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
- Remove some clothes
- 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 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 shoulders/arms/hands, remove shirt. **Take video** while child:
 rotates extended arm in circle flexes elbow/hands
- If problem with legs/feet remove shoes/socks and roll up pants to expose Primary Diagnosis. If problem with hips 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: _____