SHALOM PROJECT MINISTRY TRIPS

OLIVET NAZARENE UNIVERSITY

Travel and Medical Information

Please fill out both sides of the informational sheet. Return to the Shalom Project Office (balcony of Ludwig Student Center) by MONDAY NOVEMBER 18, 2019. This information will be confidential and kept in a secure location.

Personal Information

School ID Number:

____

Full Name (as appears on your passport/birth certificate):

______________________ ______________ ____________________

First Name Middle Name Last Name

Location:

____

Leaders Names:

____

Travel Information

If you are traveling on an international team, **please submit a color copy of your passport along with this form** and fill out all the information in the travel info section. We will keep the copy of your passport and this form in a secured location.

Have you ever been issued a passport? (please circle one)

Yes / No

Passport Country

- USA
- Other: ________________________

If yes, answer all below…...

Name as it appears on passport ____________________________________

Passport Number ____
Expiration Date ____
Place of Authority ____
Issue Date ____

Last Name at Birth ________________________________

(if different than what is provided above)

State of Birth ________________________________

City of Birth ________________________________

Citizenship ________________________________

Any other citizenship held present/past ________________________________

Date of Birth (DOB) ________________________________

Marital Status

- O Married
- O Single

If married, give maiden name ____________________________

If married, give spouse's name and citizenship:

____

Have you ever visited your assigned country before? (If yes, please provide the in-country address and dates of visit):

Please list all countries and date of visit that you have previously visited in the last 5 years:

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Medical Information

Do you have medical insurance? (please circle one) Yes / No

Insurance Company: ____
Physician's Name: ____
Physician's Phone: ____

Do you have any allergies to the following: If YES, please say to what and what the reaction is:

Medications ____
Food Intolerance ____
Insects ____
Other ____

Please mark whether you have or had any of the following diagnosed medical conditions:

- O Allergies (seasonal)
- O Anxiety
- O Asthma
- O Diabetes
- O Depression Disorder(frequent)
- O Epilepsy/seizures
- O Neurological Condition
- O Infectious Disease
- O High Blood Pressure
- O Malaria
- O Hepatitis
- O Chicken Pox
- O Migraine Headaches (frequent)
- O Anemia
- O Panic Attacks
- O Surgeries
- O Serious Accidents
- O Physical Disability
- O Urinary Tract Infections (frequent)
- O Arthritis
- O Back Problems (frequent, limiting)
- O Eating Disorder
- O Sinus Infections (frequent)
- O Obsessive Compulsive Disorder
- O Bipolar Disorder
- O Post-Traumatic Stress Disorder
- O Any other chronic/serious conditions: ______________________

If YES, to any of the above, please describe how the condition is being or was treated, and the last time you were diagnosed or treated for this condition.

Do you have any health or physical limitations that could affect you on your trip? (please circle one)

Yes / No

If YES, please explain

____

Have you been in good health the past 12 months? (please circle one)

Yes / No

Do you have any significant chronic medical conditions requiring on-going medical supervision or treatment, or have you had in the past any significant condition which is currently in remission? (ex: diabetes, heart problems, chronic or recurrent gastrointestinal disorder, seizure disorder, treatment of cancer, bleeding disorder, etc.) (please circle one)

Yes / No

If YES, please explain

____

Are you currently receiving or have you received in the past TWO years counseling for any emotional problem, psychiatric, or eating disorder?

If YES, please describe:

Do you have any dietary restrictions? If yes, please explain:

Please list all medications you are currently using:

I verify that all the information provided on this document is complete and accurate.

Signature: ____ Date: ___________________