NO BOUNDARIES MINISTRY

Holy Land Tour Application

ATTACH PHOTO HERE

Date of Application______/______/______

Trip Location: ISRAEL

General Information **(Please print or type)**

Passport Full Name ____

First Middle Last

Current Address____Apt. # ________

City____________________St____Zip________Phone (_____)____________; (_____)____________

Email____T-Shirt size____________________

Date of Birth_____/_____/______Age______Sex: ☐Male ☐Female Marital Status ______________

Citizenship______________ Passport #____________________________ Exp. Date__________

Names and Phone # of 3 Family Members____

____

____

Referred by____

How did you hear about this trip?____

Signature____**Date**____________________

NOTICE

A copy of the following documents and deposit must be submitted with the completed application form before a person is added to the Israel trip.

Copy of Driver's License, Passport, & $250.00 Trip Deposit

Return completed application form along with other required documents to:

No Boundaries Ministry, 9020 Mcilwaine Road, Huntersville, NC 28078

Make checks payable to: No Boundaries Ministry

Confidential Medical History Form

Date___________________

Please answer all questions. Explain any 'YES' answers in the space provided below.

HAVE YOU EVER HAD, OR DO YOU HAVE, ANY OF THE FOLLOWING?

□ Abnormal Blood Pressure
□ Allergies
□ Anemia
□ Anorexia Nervosa
□ Appendectomy □
Asthma
Back Problems
□ Broken Bones
□ Bulimia
□ Diabetes
□ Dislocation of Joints
□ Ear Trouble
□ Eating Disorders
□ Epilepsy

□ Eye Trouble
□ Fainting/Dizziness □
Gall Bladder Problems □
Head Injury
□ Heart Trouble
□ Hepatitis
□ Hernia Repair
□ Insomnia
□ Intestinal Troubles
□ Jaundice
□ Kidney Disease □
Knee Problems □
Mental Disorders □
Paralysis

□ Penicillin Allergy
□ Recurrent Diarrhea
□ Recurrent Headache
□ Rheumatism/Arthritis
□ Shortness of Breath
□ Skin Conditions
□ Stomach/duodenal ulcer
□ Surgery
□ Tonsillectomy
□ Tumor; Cancer
□ Venereal Disease
□ Weakness
□ Other (specify)

____
____
____

Are you allergic to any of the following? If yes, please describe your reaction and how you treat it.

Environmental Agents Foods Insect Bites Medication (penicillin, aspirin, other drugs Other

____
____

Do you have any physical handicaps or health conditions that require special attention? Explain.

____
____

Are you now, or have you recently been, under a doctor's care for any conditions? If yes, explain.

____
____

Do you presently take any medication on a regular basis? If yes, explain.

____
____

Notarized Consent Form for Adult

MEDICAL RELEASE, CONSENT FOR TREATMENT, LIABILITY RELEASE

In case of unconsciousness, or inability to release myself for medical treatment resulting from an accident on the trip that requires medical attention, I,________________________________, give my permission to No Boundaries Ministry, its representatives and all attending health care professionals (including but not limited to registered nurses, licensed practicing nurses, physicians' assistants, doctors and paramedics) to hospitalize, anesthetize, or perform surgery on me as is required. I,_____, the undersigned, release, acquit, discharge and covenant to hold harmless No Boundaries Ministry and its representatives from all actions, damages or liabilities arising out of treatment of any sickness or accident incurred by my participation on the trip. It is the intention of this release that No Boundaries Ministry and its representatives incur no liability whatsoever while attempting to meet all medical needs that I may require during the trip.

I understand that I am personally responsible for any medical expenses that may be incurred on my behalf.

I hereby release No Boundaries Ministry its agents, employees, and volunteer assistants from any liability whatsoever arising out of an injury, damage, or loss which may be sustained by said person(s) during the course of involvement with No Boundaries Ministry.

Dated this___________day of________________, 20___.

____

Passport Applicant's Signature

State of____________________, County of_______________. Sworn to and subscribed to me this

___________day of_________________, 20___

Notary Public Signature ____

*My commission expires*__________________