

# No Boundaries Ministry

Phone 704-458-3696

## Holy Land Tour Application

Date of Application \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Trip Location: ISRAEL

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

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 must be submitted with the completed application form:

Driver's License • Birth Certificate • Copy of 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

ATTACH  
PHOTO  
HERE

## 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?

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Abnormal Blood Pressure | <input type="checkbox"/> Eye Trouble           | <input type="checkbox"/> Penicillin Allergy     |
| <input type="checkbox"/> Allergies               | <input type="checkbox"/> Fainting/Dizziness    | <input type="checkbox"/> Recurrent Diarrhea     |
| <input type="checkbox"/> Anemia                  | <input type="checkbox"/> Gall Bladder Problems | <input type="checkbox"/> Recurrent Headache     |
| <input type="checkbox"/> Anorexia Nervosa        | <input type="checkbox"/> Head Injury           | <input type="checkbox"/> Rheumatism/Arthritis   |
| <input type="checkbox"/> Appendectomy            | <input type="checkbox"/> Heart Trouble         | <input type="checkbox"/> Shortness of Breath    |
| <input type="checkbox"/> Asthma                  | <input type="checkbox"/> Hepatitis             | <input type="checkbox"/> Skin Conditions        |
| <input type="checkbox"/> Back Problems           | <input type="checkbox"/> Hernia Repair         | <input type="checkbox"/> Stomach/duodenal ulcer |
| <input type="checkbox"/> Broken Bones            | <input type="checkbox"/> Insomnia              | <input type="checkbox"/> Surgery                |
| <input type="checkbox"/> Bulimia                 | <input type="checkbox"/> Intestinal Troubles   | <input type="checkbox"/> Tonsillectomy          |
| <input type="checkbox"/> Diabetes                | <input type="checkbox"/> Jaundice              | <input type="checkbox"/> Tumor; Cancer          |
| <input type="checkbox"/> Dislocation of Joints   | <input type="checkbox"/> Kidney Disease        | <input type="checkbox"/> Venereal Disease       |
| <input type="checkbox"/> Ear Trouble             | <input type="checkbox"/> Knee Problems         | <input type="checkbox"/> Weakness               |
| <input type="checkbox"/> Eating Disorders        | <input type="checkbox"/> Mental Disorders      | <input type="checkbox"/> Other (specify)        |
| <input type="checkbox"/> Epilepsy                | <input type="checkbox"/> Paralysis             |   |

Females Only

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Irregular Periods | <input type="checkbox"/> Severe Cramps | <input type="checkbox"/> Are you pregnant? |
|--|--|--|

Explain

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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

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

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

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

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**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\_.

\_\_\_\_\_  
Applicant's Signature

State of \_\_\_\_\_, County of \_\_\_\_\_. Sworn to and subscribed to me this  
\_\_\_\_\_ day of \_\_\_\_\_, 20\_\_.

Notary Public Signature \_\_\_\_\_

My commission expires \_\_\_\_\_