

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, Covid Vaccination Card & \$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?

- | | | |
|--|--|---|
| <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 | |

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 _____