



# Center for Holy Lands Studies – Medical Information

Name \_\_\_\_\_ Trip Date \_\_\_\_\_

- YES  NO Do you have a heart condition or pacemaker?
- YES  NO Are you diabetic?
- YES  NO Are you currently under a doctor’s care for a medical condition?  
**IF YES**, please provide a brief explanation and offer a statement of emergency treatment.

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- YES  NO Are you allergic to any foods or food related items?  
**IF YES**, please provide a brief explanation and offer a statement of emergency treatment

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**IF YES** to any of the medical issues noted above, please provide the name, phone, and fax number of a physician to contact in the event of a medical emergency.

Physician’s Name \_\_\_\_\_

Phone \_\_\_\_\_ Fax \_\_\_\_\_

### **REQUIRED: PROOF OF MEDICAL INSURANCE**

A photocopy of information indicating that you do have medical insurance covering you while traveling overseas is required. **Please include** a photocopy of the specific paragraph related to overseas coverage. There is every likelihood your existing personal medical insurance **does** cover you for overseas travel. Check your policy or contact your personal insurance agency for verification of coverage.