ORU
ORAL ROBERTS UNIVERSITY

ORAL ROBERTS
EVANGELISTIC ASSOCIATION

EMERGENCY INFORMATION

Use **complete formal names** as they appear on your passport (no nicknames).

□ Mr. □ Ms. □ Mrs. _____
First (Please Print) Middle Last

Address or Residence Hall: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell Phone: _____ Pager: _____

Email Address: _____

Date of Birth: _____ S.S. No. _____-____-_____
Month/Day/Year

□ Yes, I am an American citizen. □ No, I am **not** an American citizen.

If not an American citizen:

Country of Birth: _____ Country of Citizenship: _____

Please attach copy of valid Passport. Passport No. _____

EMERGENCY CONTACTS:

Name of Doctor: _____ Phone: _____

Emergency Contact: _____ Phone: _____

Relationship: _____ Cell Phone: _____

Emergency Contact: _____ Phone: _____

Relationship: _____ Cell Phone: _____

Do you have medical insurance? □ Yes □ No

Insurance Company Name: _____

Policy No.: _____ Phone: _____

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Are you currently taking any medications, including over-the-counter medications? ____

Medication	Dosage	Condition

Any Travel Participant going abroad with any preexisting medical problems should carry a letter from the attending physician, describing the medical condition and any prescription medications, including the generic name of prescribed drugs. Any medications being carried overseas should be left in the original containers and be clearly labeled. The Travel Participant should check with the foreign embassy of the country being visited to make sure any required medications are not considered to be illegal narcotics.

HEALTH STATEMENT

Please indicate past or present illnesses or conditions:

Allergies _____
Amoebic dysentery _____
Asthma _____
Diabetes _____
Epilepsy _____
Foot/leg difficulties _____
Gastro-intestinal difficulties_____
Heart difficulties_____

Hepatitis _____
Hypertension _____
Hypoglycemia _____
Infectious mononucleosis _____
Kidney trouble _____
Pregnancy _____
Malaria _____
Migraine headaches _____

Paralysis _____
Pneumonia _____
Rheumatic fever _____
Tuberculosis _____
Ulcers _____
Other _____
_____
_____

Have you been treated in the last three years for any mental or emotional condition? _____

Are you currently on any drug for treatment of mental or emotional condition? _____

If your answer is yes to either of the above, please give a brief explanation and also the name, address, and phone number of your physician or counselor for reference. _____

_____

_____

To the best of my knowledge, the above information is complete and correct.

_____ Date

_____ Signature