TOUR: DATE:

(Please type name as it appears on official ID for purchase of airfare)

First Name

Last Name

Passport #

Exp. Date Sex : ☐ Male ☐ Female

Birth Date

Month Day Year

Address

Street Address

City

State / Province Postal / Zip Code

Home Phone Mobile Phone

E-mail

Name for Name Tag

Dietary Restrictions

None

HEALTHY TRAVELING MEDICATIONS: If you require any special medications, we suggest that you carry them along with you in their original prescription containers.

EMERGENCY CONTACT INFORMATION

Activity: Date:

Name:

Allergies/Medical Conditions/Medications:

I, , agree that in the event I am injured as a result of my participation in the above-named activity, including transportation to and from these activities, whether or not caused by the negligence (active or passive) recourse for the payment of any hospital, medical, dental, or related costs and expenses will be paid either by me or my spouse, accident, hospital or medical insurance, or any available benefit plan of mine or my spouse.

I consent to any x-ray examination, anesthetic, medical or surgical diagnosis or treatment and hospital care under the general or special supervision and upon the advice of or to be rendered by a licensed physician, surgeon, or dentist. I am responsible for my own health care decisions and am authorized to consent to services to be rendered, and no other consent is required by law.

If I am incapacitated, I hereby give permission to the physician selected by the activities supervisory personnel then present to render medical treatment deemed necessary and appropriate by the physician, surgeon or dentist.

I acknowledge that this activity has inherent risks of injury and loss, and that other hazards or risks, inherent or otherwise, may be encountered. I agree to release and indemnify Revival Tours and it's leaders from any and all claims of injury or other loss or damage arising in whole or part from my participation in this activity.

_____

Signature Date

Print Name

Home Phone: Cell Phone:

Emergency Contact:

Home Phone: Cell Phone:

Name & Phone of Primary Doctor:

Health Insurance Plan & Policy Number: