

Personal Information (please print clearly)

Name: _____ APU Student ID: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____

 Will you be taking this cell phone with you while out of the country? (Check with carrier) **YES** **NO**

APU Email: _____ Box #: _____

 *** **IMPORTANT: APU will use this email address to stay in contact with you while you are abroad.**

Date of Birth: _____ Social Security #: _____

Optional – medical insurance purposes only

Ethnic Background (Optional):

- | | | | |
|--|---|---|--------------------------------|
| <input type="checkbox"/> American Indian/Eskimo | <input type="checkbox"/> Black/Non-Hispanic | <input type="checkbox"/> Middle Eastern | <input type="checkbox"/> Other |
| <input type="checkbox"/> Asian of Pacific Islander | <input type="checkbox"/> Hispanic | <input type="checkbox"/> White/Non-Hispanic | |

 Gender: Male Female

Educational Data

 Academic Major: _____ Academic Level: Freshman Sophomore Junior Senior

Academic Advisor: _____

Expected Graduation Term (i.e. December, 2050): _____

Study Abroad Information

Study Abroad Program: _____ Country/Countries: _____

 Dates of Program: _____ Exact Dates of Travel: _____
(incl. additional travel dates) to purchase International Insurance

 Passport #: _____ Passport Expiration Date: _____
 (Please provide the Office of Study Abroad a copy of your passport.)

 I give permission to the Study Abroad Office to share my email address with other prospective study abroad students **YES** **NO**
Emergency Contact Information

Name: _____ Relationship: _____

Phone Number: _____ Cell: _____

Health Report

Primary/Family Doctor: _____ Phone Number: _____

Do you have any of the following?

(please Circle one) If yes, please describe?

If yes, please describe?

Allergies	Yes	No	_____	Learning Disability (Optional)	Yes	No	_____
Food Allergies	Yes	No	_____	Heart Condition	Yes	No	_____
Medication Allergies	Yes	No	_____	Heat exhaustion	Yes	No	_____
Asthma/ Other Respiratory Problems	Yes	No	_____	High Blood Pressure	Yes	No	_____
Back trouble	Yes	No	_____	Nose Bleeds	Yes	No	_____
Diabetes	Yes	No	_____	Physical Handicap	Yes	No	_____
				Sinus Problems	Yes	No	_____

Other (please explain):

Do you need a special diet? If so, please describe. _____

 Do you take any medications regularly? _____
 (Please bring a complete supply of your prescription for the entirety of the trip. Also, have a valid copy of your prescription with you.)