SOUTHERN WESLEYAN UNIVERSITY

SWU Student Travel Form

Last Name: _____ First Name: _____ Middle: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: (_____) _____- _____ Work Phone: (_____) _____ - _____

Cell Phone: (_____) _____ - _____ Email: _____

Male Female Birth Date: _____ / _____ / _____

Prescription medication? YES / NO

What medication(s): _____

Dosage: _____

Non-prescription medication? YES / NO

What medication(s): _____

Dosage: _____

Allergic to any foods/medications? YES / NO

What foods/medication: _____

Under physician's care for illness? YES / NO

Explain: _____

Date of last physical exam? _____/_____/_____

Type	Yes	No	Year
Mumps/Measles/Rubella			
Tdap			

Emergency Contact Information

In case of emergency, please contact:

Name: _____ Relationship to Applicant: _____

Home #: (____) _____ Work #: (____) _____ Cell#: (____) _____

_____

Signature of Participant or Parent/Guardian