Operation Renewed Hope *General Waiver/Medical Release*

P.O. Box 43242, Fayetteville, NC 28309, (910) 987-5072 (Cell), www.operationrenewedhope.org

(Please, write legibly)

Name:					
Address:					
Address:					
City:		**State:**		**Zip:**	
Home Phone:					
Emergency Contact:		**Phone:**			
Allergies or Allergic Reactions:					
Special Conditions:					
Medicine-Allergic Reactions:					
Medicine Currently Taking and Dosage:					
Date of Birth:		**Age:**			
Ins. Company:		**Policy #**			
Agent Name:		**Group #**			
Dentist:		**Phone:**			
Physician:		**Phone:**			
Physician:		**Phone:**			

Trip Name: Uganda October 21 – 29, 2017
General Waiver and Release

I, _____, request to travel with Operation Renewed Hope, Inc,, hereafter referred to as ORH, on the above listed mission, hereafter referred to as specified activity, and hereby waive and release ORH, its agents, board, and any and all other parties under or affiliated with ORH from liability pertaining to any and all matters relating to the specified activity. I understand that by signing this waiver and release, I expressly and willingly assume complete responsibility for any risk of injury or illness that may arise from the specified activity. On behalf of my heirs, assigns, and next of kin, I waive all claims for damages, injuries, illnesses, mental or emotional distress, disease, and/or death sustained by me or to my property, that I may have against the above named released party; ORH, its agents, board, and any and all parties under or affiliated with ORH, relating to the specified activity or training. I realize that I am relinquishing future rights.

I understand that the airfare that I pay for in my trip cost is strictly for the specified activity. If, for any reason or circumstance, I do not make use of, am denied use of, or fail to make the connections of this airfare while on the specified activity, I am responsible for any and all costs that might be incurred in making other arrangements to continue and/or finish the travel of the specified activity.

I, understand and acknowledge that the liability of ORH for personal injury claims may not exceed the most current insurance policy in effect for such purposes, and I also understand and acknowledge that I may only receive a portion of this, if anything, because of multiple claims.

I have read, understand, and agree completely with all the terms and specifications in the Standard Clinic Operation Procedures Manual of Operation Renewed Hope. I also accept full responsibility for the announced cost of the specified activity. I understand that there is no refund of money. I agree to pay the entire trip cost, promptly, regardless of whether I attend the trip.

I give permission for ORH to use my image, vital information, and name in any and all media publications of ORH.

 Initials and Date: _____ _____

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Medical Release

To Whom It May Concern:
If I should need medical treatment, and I am unable to speak for myself; I authorize Operation Renewed Hope leadership to obtain medical treatment for me. I authorize access to any and all of my medical records in order to secure appropriate medical treatment for me. I authorize them to admit me to a hospital or medical facility for diagnosis and treatment. I authorize them to approve physicians, dentists, and staff, duly licensed as Doctors of Medicine or Doctors of Dentistry or other such licensed technicians or nurses, to perform any diagnostic procedures, treatment procedures, operative procedures and imaging treatment. I acknowledge that I have not been given a guarantee as to the results of examination, diagnosis, treatment or cure. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from my body. I accept full financial responsibility for any and all medical treatment or care obtained. I accept the full responsibility for the decisions that might be made in my behalf as a result of this medical power of attorney. I authorize the leadership of ORH to inform the following people of my condition or needs.

Name: **City/State** **Phone 1** **Phone 2** **Email**

_____
_____
_____

FURTHERMORE, IN VIEW OF THE FACT THAT OPERATION RENEWED HOPE IS A NON-PROFIT, FAITH-BASED, CHARITABLE ORGANIZATION, I AGREE NOT TO HOLD ORH LIABLE FOR ACTS OF OMISSION, AND/OR COMMISSION, THAT MAY OTHERWISE ARGUABLY CONSTITUTE NEGLIGENCE IN A COURT OF LAW.

This signature is for the Waiver and Release of Liability for Operation Renewed Hope, and the Medical Release.

Signature: _____Date: _____

Parent or Legal guardian: _____Date: _____

PLEASE HAVE THREE ORIGINALS NOTARIZED

Name of Notary: _____
Notary Authorization: _____
Date of Notary Expiration: _____

I affirm that the above signature(s) appeared before me and signed this document this _____ day of _____, _____, in the county of _____, state of _____.

Notary Seal:
Signature: _____

Please, mail one original to Operation Renewed Hope, 2150 Storm Canyon Rd, Winston Salem, NC 27106. Bring two originals on the trip. Give one to the trip team leader. Keep one on your person at all time.

 Initials and Date: _____ _____