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:**			

Specified Activity: __Dominican Republic2019_____

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 in my trip cost is strictly for the initial trips of 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 initial 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.

 Initials and Date: _____ _____

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

Medical Release

To Whom It May Concern:
If I should require medical help, and I am unable to speak for myself; I authorize Operation Renewed Hope leadership, hereafter known as "ORH", to obtain medical care for me. I authorize ORH to be given access to any and all of my medical records, such records to be used as ORH determines in order to secure medical care for me. I authorize ORH to admit me to a hospital or facility for medical care including extended care. I authorize ORH to acquire and approve medical professionals, facilities, and staff, to perform any medical procedures such as, but not limited to, diagnostic procedures, treatment procedures, operative procedures, and imaging procedures required for my care. I authorize ORH to acquire, approve, and allow pharmaceuticals to be administered to me. I acknowledge that I have not been given a guarantee from any source as to the results of the medical care obtained by ORH. I authorize ORH to give permission to a hospital or medical facility to dispose of any specimen or tissue taken from my body. I release ORH from all financial responsibility relating to my needs, and I personally accept financial responsibility for 100% of any and all charges of my medical care or extended care related to my medical needs. 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: _____ _____