

Operation Renewed Hope

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

Medical Release Form

Missionary: Dr. JD Moses
Chitra Nilaya, 3rd Cross Kittur Channamma Layout
Bhadravathi 577 301 Karnataka
011 91 9632 300838

General Waiver and Medical Release for Operation Renewed Hope (Please, write legibly)

Name:			
Address:			
Address:			
City:		State:	
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:	

India November 2011
November 26 – December 4, 2011
(Specified Activity)
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, and 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 or make proper connections with 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 specified activity.

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I have read, understand, and agree completely to the Standard Operation Procedures Manual of Operation Renewed Hope. I also accept full responsibility for the announced cost of this trip. I understand that there is no refund of money. I agree to pay the entire trip cost, promptly, when billed regardless of whether I attend the trip for any reason.

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 x-ray 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 signatures appear 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, 4928 Necessary Ct, Blue Springs, MO 64015. Bring two originals on the trip to give to the trip team leader.