**(Please, write legibly)**

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| --- | --- |
| **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: \_\_\_\_\_\_\_\_\_\_\_ ORH MEDICAL TEAM**

**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 original 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.

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. I give permission for my image and voice to be used by ORH in media productions.

**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, 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 according to their discretion.

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**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 NOTARIZED MEDICAL RELEASE TO ORH, 4205 WEAVER DR, RALEIGH, NC 27612-3031. BRING TWO ORIGINAL NOTARIZED MEDICAL RELEASES ON THE TRIP. GIVE ONE TO THE TRIP TEAM LEADER. KEEP ONE ON YOUR PERSON AT ALL TIMES.**