

Circle of Hope International

615 Bohicket Road

Wilmore KY 40390

ASSUMPTION OF RISK AND RELEASE FROM LIABILITY (“Release”)

I am signing this Release so that I can participate as a voluntary team member on a mission trip to Malawi, Africa with Circle of Hope International.

The dates of my trip are from \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

I understand that my participation in this Activity is voluntary.

I understand that there are certain risks inherent in this Activity, including any associated travel, meal and lodging. These risks may include but are not limited to accidents; exposure to adverse weather conditions; theft; loss; or damage of personal property; war; quarantine; civil unrest; public health risks; criminal activity; terrorism; exposure to communicable diseases; ill effects of unfamiliar food and water, incidents related to ground air or water transportation; physical, mental and emotional injuries; and catastrophic death.

I confirm that I have consulted the Center for Disease Control website at [www.cdc.gov/travel/](http://www.cdc.gov/travel/) and reviewed its travel health recommendations, including routine, recommended and required vaccinations associated with this Activity. I assume sole and complete responsibility for my travel health and vaccinations.

I confirm that I have consulted the U.S. Department of State website at <http://travel.state.gov/> and reviewed its international travel information and travel tips specifically pertaining to this Activity.

I understand that Circle of Hope International (hereinafter referred to as Circle of Hope) is not responsible for any loss or damage to person or property that I may suffer when I am traveling independently or I am otherwise separated or absent from any Circle of Hope sponsored activity. In addition, I understand that any travel that I do independently on my own before or after the conclusion of the Activity is entirely at my own expense and risk. If I become separated from the Activity group, fail to meet a departure airplane, bus or train, or become sick or injured, I will to a reasonable extent, and at my own expense, seek out, contact and reach the group at its next available destination.

I understand that Circle of Hope is not an agent of, and has no responsibility for, any third party which may provide any services including food, lodging, travel, or other goods or services associated with the Activity. I understand Circle of Hope is providing these services only as a convenience to participants and that according, Circle of Hope accepts no responsibility, in whole or in part, for delays, loss, damage or injury to persons or property whatsoever, caused to me or others prior to departure, while traveling or while staying in designated lodging. I further understand that Circle of Hope is not responsible for matters that are beyond its control. I acknowledge that Circle of Hope reserves the right to cancel the trip without penalty or to make any modifications to the itinerary and/or program as deemed necessary by Circle of Hope. I also acknowledge that Circle of Hope is not obligated to refund any fees if Circle of Hope cancels the trip as a result of a United States Department of State travel advisory for any country that is part of the Activity or as a result of any other safety or health related issues as deemed necessary by Circle of Hope.

I agree to assume the risk that unexpected events may occur and result in harm, injury, illness or death to me or damage to my personal property or effects while I am participating in or observing the Activity or while I’m traveling to or from the Activity. I further agree to release and hold Circle of Hope International, Its Board of Directors and any of its employees harmless from any and all liability which could result from this Activity.

If I require emergency medical treatment, please contact:

Name of Emergency Contact Person: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I consent to the provision of emergency medical treatment to the extent that the treatment is necessary in the medical opinion of the licensed doctor rendering the treatment. I also agree that any medical expenses that I might incur due to my involvement in this Activity will be my responsibility.

I confirm that all questions about the risks I am assuming have been fully answered to my satisfaction.

If any portion of this Release is held invalid, the rest of the document shall continue in full force and effect. The interpretation and performance of this Agreement shall be construed in accordance with the laws of the Commonwealth of Kentucky, and any litigation arising out of this Agreement shall be venued in the Commonwealth of Kentucky and shall be governed by the laws of the Commonwealth of Kentucky.

Participant Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Participant Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Passport:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birthdate: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Witnessed By:

I confirm that I have witnessed (Name of Participant) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ sign and date this document.

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to the Participant: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_