



**APPLICATION TO PARTICIPATE,
CONSENT TO MEDICAL OR DENTAL CARE,
WAIVER AND RELEASE OF LIABILITY,
PERMISSION TO USE PHOTOGRAPHS AND
MEDICAL AND PERSONAL INFORMATION**

Application to Participate The undersigned (referred to as VOLUNTEER) volunteers and asks to participate in a LIONS IN SIGHT sponsored CLINIC MISSION (referred to as the TRIP), and to travel with the other people participating in the TRIP (referred to as the TEAM), from my home to the destination specified below (referred to as the DESTINATION), on the dates described below (referred to as the DATES OF TRAVEL).

Consent to Medical or Dental Care LIONS IN SIGHT representatives, and other members of the TEAM are authorized to employ such emergency or other medical and dental treatment as the emergency personnel deem necessary or appropriate under the circumstances, and to return my remains and possessions as directed by the persons listed below (referred to as the ALTERNATE CONTACTS) and the Embassy of the United States at the DESTINATION, if I die while on the TRIP. I understand that LIONS IN SIGHT will use all reasonable efforts to contact the ALTERNATE CONTACTS if I am unable to authorize such treatment myself, before the administration of any non-emergency treatment, but if they are unable to contact anyone, they are authorized to allow and authorize any such necessary medical and dental care. I understand that they will continue to try to contact the ALTERNATE CONTACTS even while such treatment is continuing. I acknowledge that if I am covered by Medicare for my medical expenses, it may not cover me on the TRIP, and I may need to acquire my own private supplemental insurance coverage.

Waiver and Release of Liability VOLUNTEER acknowledges that the TRIP will involve physical work and activity in excess of that in which I usually participate, and in surroundings that may not be comfortable to me. I understand that LIONS IN SIGHT will attempt to safeguard my health and safety at all times, and I hereby waive and release and agree to hold LIONS IN SIGHT, LIONS CLUBS INTERNATIONAL, and all divisions, clubs and districts thereof, and any and all employees, agents, representatives or agents, from any liability for any injury, damage, cost or expense to me or my estate, arising out of or resulting from my participation in the TRIP.

I understand that the DESTINATION of the TRIP is outside of the United States and may involve injuries, illness, delays, accidents, losses, irregularities for a variety of reasons, including, but not at all limited to airborne and insect or animal borne injuries, illnesses, insurrections, terrorism, natural disasters, altitude, food, humidity, unregulated extremes in air temperature and dangerous traffic. This releases any actions, claims, demands or complaints resulting there from which my estate or I might have against the parties released hereby at any time, now or in the future, and should be enforced unless the loss or injury results directly from the gross negligence or intentional act of LIONS IN SIGHT or one of the other released parties, or their authorized and acting agents, employees or representatives.

Permission to Use Photographs VOLUNTEER agrees to and permits the use of my likeness, photographs and quotes by LIONS IN SIGHT.

Medical and Personal Information

VOLUNTEER's name is _____,
and my full street address is _____

My telephone number is ____/_____, cell number is ____/_____,
and email address is _____.

VOLUNTEER is affiliated with _____
LIONS/LIONESS/LEOS CLUB, as a member/guest/relative of member.

An ALTERNATIVE CONTACT for VOLUNTEER is _____,
whose telephone number is ____/_____. Another ALTERNATE
CONTACT is _____, whose telephone
number is ____/_____.

VOLUNTEER was born on _____ at
_____, _____, _____.
VOLUNTEER is a citizen of the United States, and carries United States
Passport Number _____, issued on _____.

VOLUNTEER has the following food, drug or other allergies:

_____.

VOLUNTEER's last Tetanus shot was on _____.
VOLUNTEER is taking the following medication: _____

_____.

VOLUNTEER's medical or health insurance provider is
_____, whose address is
_____,
and telephone number is ____/_____, under Policy, Group or Card
Number _____.

VOLUNTEER's primary care physician _____
whose telephone number is ____/_____.

DESTINATION of the TRIP is _____.

DATES OF TRAVEL are _____ through _____.

ACKNOWLEDGEMENT

VOLUNTEER declares under penalty of perjury under the laws of the State of California, that the foregoing information is true and correct.

Dated: _____

Signature of VOLUNTEER

Printed Name of VOLUNTEER

STATE OF _____)

) ss.

COUNTY OF _____)

On _____, before me, _____,
personally appeared _____,
who proved to me on the basis of satisfactory evidence to be the person(s)
whose name(s) is/are subscribed to the within instrument and
acknowledged to me that he/she/they executed the same in his/her/their
authorized capacity(ies), and that by his/her/their signature(s) on the
instrument the person(s), or the entity upon behalf of which the person(s)
acted, executed the instrument.

I certify under PENALTY OF PERJURY under the laws of the State of California that the foregoing paragraph is true and correct.

WITNESS my hand and official seal.

Signature _____ (Seal)