

2023 EYE CARE MISSION  
RELEASE OF LIABILITY AND WARNINGS  
AND STATEMENT OF EACH PARTICIPANT'S PERSONAL RESPONSIBILITY

I, (we) \_\_\_\_\_, along with all members of my (our) family, including my (our) heirs, personal representatives, successors and assigns, in consideration of the benefits derived, hereby voluntarily waive any claims against the organizers, or any other participants, on this project. In fact, the organizers of this trip cannot and do not risk their family's financial security by organizing this trip. This is not a "common venture" in which participants "share the responsibility" for the conduct of this trip.

Special insurance will be purchased for each participant however each participant in the trip must decide for himself/herself whether he/she has the appropriate health and medical insurance to safely participate in this trip, including, but not limited to, whether said coverage extends to a foreign country. Each individual is responsible for his/her own decisions and for ensuring that he/she has the proper health and medical coverage.

The undersigned fully and completely understand(s) the risks involved in participating in this project, and voluntarily and freely accepts(s) and assume(s) the same without any recourse against the organizers and/or other participants.

The participants(s) named above assume(s) the risk of death or injury inherent in this trip. The participant waives any claim which may arise against the organizers for death or injury to person or property, including claims of vicarious liability and claims arising from civil recklessness or any degree of negligence. This Waiver shall be broadly construed in favor of protecting the organizers and participants from liability.

If the participant is a minor, this form must be signed by a parent or guardian.

Passport number: \_\_\_\_\_ Exp. Date \_\_\_\_\_ Date of birth: \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_ T-shirt size: \_\_\_\_\_

I have been vaccinated (initial) \_\_\_\_\_

Passport number: \_\_\_\_\_ Exp. Date \_\_\_\_\_ Date of birth: \_\_\_\_\_

Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_ T-shirt size: \_\_\_\_\_

I have been vaccinated (initial) \_\_\_\_\_

Emergency Contact:

Name/relationship: \_\_\_\_\_

Phone: \_\_\_\_\_

Participant/Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_

Participant/Guardian Signature: \_\_\_\_\_ Date \_\_\_\_\_

Will meet bus at (please check one): Airport \_\_\_\_\_ Hotel Quality \_\_\_\_\_

Return this form to: Eye Care Int, Attn: Tad MacDonnell, 435 Elliott Road, Centerville, MA 02632