

**Important:** Each participant must have a signed "Release and Waiver of Liability" on file. Please complete this form now in order to be considered. Please print information in blanks provided.

**PLEASE READ CAREFULLY! THIS IS A LEGAL DOCUMENT!**

## John M. Perkins Foundation Release and Waiver of Liability

This Release and Waiver of Liability (the "Release") executed on this \_\_\_\_\_ day of \_\_\_\_\_, 2002 by \_\_\_\_\_ (the "Volunteer") in favor of JOHN M. PERKINS FOUNDATION (JMPF) AND THE SPENCER PERKINS CENTER (SPC), a nonprofit corporation organized and existing under the laws of the State of Mississippi, USA, its affiliated organizations in other names, its, directors, officers, employees, and agents (collectively, the "Foundation").

I, the Volunteer/Intern, desire to work as a volunteer for the John M. Perkins Foundation/Spencer Perkins Center (JMPF/SPC), and engage in the activities related to being a volunteer for a work team. I understand that the activities may include but are not limited to, traveling to and from other cities and towns, consuming food and living in accommodations available and provided, working in the JMPF/SPC offices, constructing and rehabilitating residential buildings and other construction-related activities.

I, the Volunteer/Intern, hereby freely and voluntarily, without duress, execute this Release under the following terms:

1. **Waiver and Release.** I, the Volunteer/Intern, release and forever discharge and hold harmless the JMPF/SPC and its successors and assigns from any and all liability, claims, and demands of whatever kind or nature, either in law or in equity, which arise or may hereafter arise from my work for the JMPF/SPC.
2. **Insurance.** I, the Volunteer/Intern, understand that, except as otherwise agreed to by the JMPF/SPC in writing, JMPF/SPC does not carry or maintain health, medical, or disability insurance coverage for any volunteer.
3. **Medical Treatment.** Except as otherwise agreed to JMPF/SPC in writing, I hereby release and forever discharge JMPF/SPC from any claim whatsoever which arises or may hereafter arise on account of any first-aid treatment or other medical services rendered in connection with an emergency during my time with the JMPF/SPC.
4. **Assumption of Risk.** I understand that my time with the JMPF/SPC may include activities that may be hazardous to me, including, but not limited to, construction activities, loading and unloading of heavy equipment and materials, and local transportation to and from the work sites. So, I recognize and understand that my time with the JMPF/SPC may in some situations, involve inherently dangerous activities. I also understand that in addition to consuming local foods and living in accommodations, which are available at the JMPF/SPC, I may be traveling to and from locations, which pose risks.
5. I hereby expressly and specifically assume the risk of injury, illness death or property damage resulting from the activities of my time with the JMPF/SPC.
6. **Photographic Release.** I grant and convey unto the JMPF/SPC all right title, and interest in any and all photographic images and video or audio recordings made by the JMPF/SPC during my work for the JMPF/SPC, including, but not limited to, any royalties, proceeds, or other benefits derived from such photographs or recordings.
7. **Other.** I expressly agree that this Release is intended to be as broad and inclusive as permitted by the laws of the state of Mississippi in the United States of America, and that this Release shall be governed by and interpreted in accordance with the laws of the State of Mississippi. I agree that in the event that any clause or provision of this Release shall be held to be invalid by any court of competent jurisdiction, the invalidity of such clause or provision shall not otherwise affect the remaining provisions of this Release, which shall continue to be enforceable.

To express my understanding of this release, I sign here with a witness.

**Volunteer/Intern:** Name *(Please print)* \_\_\_\_\_ Signature \_\_\_\_\_  
Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ Date \_\_\_\_\_  
**Witness:** Name *(Please print)* \_\_\_\_\_ Signature \_\_\_\_\_  
Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ Date \_\_\_\_\_

# Emergency Contact Information

(Please attach a copy of your driver's license to back of this page)

Date of Application: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_  
month day year

Your Name \_\_\_\_\_ Birthday \_\_\_\_\_

Permanent Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ Phone \_\_\_\_\_

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

## In case of emergency, please contact:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

Phone Day ( ) \_\_\_\_\_ Night ( ) \_\_\_\_\_

## Any hospital or medical practitioner not having access to your medical history may need the following information:

Allergies to medicine, food, etc.

\_\_\_\_\_

Date of last tetanus shot

\_\_\_\_\_

Physical impairments

\_\_\_\_\_

Other

### Personal Physician

Name \_\_\_\_\_

Address \_\_\_\_\_

Phone Day ( ) \_\_\_\_\_ Night ( ) \_\_\_\_\_

### Personal Health Insurance Coverage

Company \_\_\_\_\_ Policy Number \_\_\_\_\_

Insurance Agent \_\_\_\_\_ Agent's phone: ( ) \_\_\_\_\_

\*Primary beneficiary \_\_\_\_\_ Relationship \_\_\_\_\_

\*Secondary beneficiary \_\_\_\_\_ Relationship \_\_\_\_\_

Do you or any family member have a history of high or low blood pressure? YES NO  
If yes, please tell us who \_\_\_\_\_

Have you or any of your family members ever had a heart problem? If yes, YES NO

Please indicate who by the specific shown below:

a. Heart Attack \_\_\_\_\_ c. Angina \_\_\_\_\_

b. Irregular heart beat \_\_\_\_\_ d. Other \_\_\_\_\_

Do you see a cardiologist (heart doctor)? If yes, please answer the following: YES NO

When did you last see him/her? \_\_\_\_\_

What is his/her name? \_\_\_\_\_

Are you pregnant? If yes, please tell us how far along are you? YES NO

Who is your obstetrician? \_\_\_\_\_

Are you presently on any medication? If yes, please tell us what kind and what it is for: YES NO

Do you have any other medical problems that we should be made aware of? YES NO

Please specify \_\_\_\_\_

\_\_\_\_\_