Registration Form

St. Luke Mission Trip - Chiltiupan, El Salvador

February 19-23, 2025

Please complete both sides and sign this form on the reverse side

Surname (Last Name) **as listed on your passport**.

Last Name: _____

Given Names (First Name & Middle Name) **as listed on your passport**.

First Name: _____ Middle Name: _____

Date of Birth: MM: _____ DD: _____ YYYY: _____ Gender: M_____ F_____

Passport Number: _____

Passport Expiration Date: MM: _____ DD: _____ YYYY: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____ T-Shirt Size: _____

Phone Number (Cell): _____

American Airlines Advantage Number (if applicable): _____

Payment and Cancellation

Registration, waiver and medical forms and $900.00 Deposit due by **September 15, 2024**.

Final payment of $900.00 due by **November 1, 2024**.

Cancellation and Refund Policy

- Cancellation and Full Refund until November 21, 2024;
- Cancellation between November 22, 2024 and January 13, 2025: $1,300 refund as cash and/or airline credit, unless another traveler can fill the spot;
- Cancellation January 14 or later: refund may be airline credit for airfare only, subject to airline policy, unless another traveler can fill the spot.

All registrations subject to approval by the pastor.

I have read this registration form and acknowledge all policy limitations stated herein. The information I have provided is true and complete to the best of my knowledge.

Signature of traveler (or legal guardian of traveler) Date

STATEMENT OF RESPONSIBILITY/WAIVER AND RELEASE (Adults)

I,_____*(name of participant)* would like to participate in the **St. Luke El Salvador Mission Trip**_____*(title of program/activity)* to **El Salvador** _____ *(location)* (the "Program") offered by **St. Luke (Lakewood)**____ Parish (the "Parish") during the period of **_February 19-23, 2025**_____ (*dates of program*). In exchange and in consideration for the Parish's agreement to allow me to participate in the Program, I agree as follows:

- I understand the scope and nature of the Program, including but not limited to the fact that the Program involves or may involve vigorous physical activity such as substantial standing, walking, and interaction with others who are not part of Parish's group among other things. I understand the nature of the Program and have been given the opportunity to ask questions about the Program and travel to and from the Program. I understand that there are risks involved with international travel or travel abroad and that while traveling I will be subject to the laws of the country or territory in which I am traveling. It is my responsibility to assess the risk level of traveling abroad and to assess the applicability of any/all travel warnings from any governmental agency or other person, and any assurances from anyone abroad, and to comply with any governmental recommendations for any vaccinations or medication. The Parish does not make any type of representation about whether it is safe to go to any particular destination. I recognize the possibility and risk of injury associated with my participation in the Program, which may include, but is not limited to, bodily injury up to and including death, psychological injury, and further injury by medical treatment. I further recognize the possibility and risk of such injuries resulting from exposure to or infection by COVID-19 or other communicable diseases in connection with my participation in the Program and that such exposure or infection may result in my or other family members' exposure to or infection of COVID-19 or other communicable diseases. I understand that the types of injuries listed above can occur for any number of reasons which are both foreseeable and unforeseeable and which may include, but are not limited to, my own actions or inaction, the actions or inaction of others (whether negligent, intentional, or otherwise), and equipment failure. I agree to participate in the Program in spite of the risks.

- I assume all risks in connection with my participation in the Program. To the fullest extent allowed by law, I, on behalf of myself, my spouse, as well as our respective heirs and assigns, executors, all other legal representatives and any others claiming through us or on behalf of us, hereby agree to release, discharge, hold harmless and indemnify the Parish, the Catholic Diocese of Cleveland, and the Bishop of the Catholic Diocese of Cleveland, as well as their respective clergy, officers, employees, agents, representatives, attorneys, sponsors, and volunteers from and against all claims, injuries, losses, damages, judgments, and liability (of any nature or extent) which in any way arise out of or relate to or are connected with my participation in the Program, including travel to and from the Program, whether foreseen or unforeseen, regardless of the cause (including, but not limited to, the negligence of any person).

- I agree to follow the Parish's rules and cooperate with the person(s) in charge of the Progam, including all safety protocols and procedures related to COVID-19 or other communicable diseases. I understand that the Parish reserves the right to decline to accept or retain me in the Program at any time should my behavior impede program operations or the rights or welfare of any person. In such an event, no refund will be made and I will bear any costs associated with the decision to require me to leave the Program and return to the United States. I understand that the Parish may, in its sole discretion, cancel the Program before departure or cancel the Program after departure and require that all participants return to the United States. I understand that in such an event, no refund will be made and I will bear my share of any costs associated with the decision to cancel the Program and return to the United States.

- I consent and grant permission for the Parish, and affiliated parishes and/or their agents to photograph, audio record, video or otherwise record my name, image, likeness, spoken words, in any form (the "Recordings"), and to use, display, publish, distribute, or alter the Recordings, or any part thereof, for any lawful purpose including, without limitation, on social media accounts, websites, in marketing publications, public relations and communications materials and/or presentations, and any other uses as may not be contemplated herein, without further notice or compensation. I further agree that the Recordings shall constitute the sole property of the Parish, or affiliated parish taking the Recording.

- I understand that it is my responsibility to carry appropriate medical insurance for myself and that such is not the responsibility of any other person or party, including, without limitation, the Parish.

- I agree that this instrument is to be construed under the laws of the State of Ohio, and that if any portion is held to be invalid, the balance shall remain in full force and effect.

I have carefully read and understand and accept the terms and conditions stated herein and I have signed this agreement of my own free will. <u>For Online Forms:</u> By typing my name below, which shall constitute my electronic signature, I agree that my electronic signature is intended to authenticate this writing and to have the same force and effect as my manual signature.

Participant's Signature:_____Date:_____

Print Name:_____

EMERGENCY MEDICAL AUTHORIZATION AND RELEASE FOR TREATMENT (Adults)

This authorization enables a participant to authorize the provision of emergency treatment for the participant who becomes ill or injured while attending **St. Luke El Salvador Mission Trip to El Salvador, February 19-23, 2025**_____*(title of activity/program and location)* ("Program") and while in the care of or under the supervision of the Parish or its staff, employees, volunteers, agents and/or representatives. This must be signed in order for you to participate in the trip.

I hereby authorize any of the staff, employees, volunteers, agents and/or representatives of the Parish (each an "Authorized Party") to provide for, seek, and authorize medical treatment for me in the case of illness or accident from the closest and most appropriate licensed medical practitioner or hospital available.

This authorization does not cover major surgery unless the medical opinions of two licensed physicians/dentists concurring in the necessity for such surgery are obtained for the performance of such surgery.

Any and all information concerning my medical history including allergies, medications and physical impairments, has been reported in these registration forms. In the event of an emergency, I authorize any Authorized Party to share the completed registration information packet with persons related to my treatment.

Participant's Signature:_____Date:_____

Print Name:_____

MEDICAL INFORMATION

Full Name: _____Date of Birth:_____
Sex: Male ☐ Female ☐

Home Phone No.: _____Cell Phone No.: _____
Email:_____

Emergency Contact #1:
Name of Emergency Contact:_____Phone No. for Contact:_____
Relationship: _____

Emergency Contact #2:
Name of Emergency Contact:_____Phone No. for Contact:_____
Relationship: _____

Chronic Illnesses: _____
Allergies: _____
Current Medications: _____
Date of Last Tetanus Immunization: _____
Other: _____
Name of Doctor/Primary Care Physician: _____Phone: _____
Insurance Information:
Health insurance co: _____Member number: _____
Group number: _____Group name: _____