*SHUARHANDS, INC* and *NIñOS SHECANOS*

 **RELEASE OF LIABILITY**

I have voluntarily agreed to participate in an international humanitarian mission (the "Program") sponsored by *ShuarHands, Inc*. and *Niños Shecanos,* in Guatemala, Central America. I acknowledge that there may be significant potential dangers and risks as a result of the occurrence of events during my participation in the program which might cause personal injury or sickness, death, or damage to my property. I agree to participate in the program at my own risk, and I assume all risks of any kind associated with such participation. I acknowledge that I have read information on the internet from the U.S. State Department concerning the host country, and I have done any additional research on the host country that I feel is necessary to allow me to make an informed decision to take part in the program. I am an adult, 21 years of age or older. I am in good mental and physical condition which will permit me to contribute positively to this Program.

I acknowledge that *ShuarHands, Inc*. and *Niños Shecanos* carry no Malpractice Insurance, Long-term Disability Insurance, Workers Compensation Insurance, Traveler's Insurance, nor Liability Insurance.

In consideration of *ShuarHands, Inc*. and *Niños Shecano*s’sponsorship of the program, and its decision to allow me to participate, I hereby waive, release and forever discharge *ShuarHands, Inc*. and *Niños Shecanos* and its employees, agents, directors, sponsors, promoters, and volunteers from any and all liability, claim, damage, loss, cost or expense arising from or attributable in any way to any of the events enumerated in the preceding paragraph or any action, omission to act, or negligence of any such person or organization in connection with the sponsorship, organization or performance of services associated with the trip, including related travel.

Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Signature of Volunteer

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Please print your name

 Office Use only

Date received\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Travel\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Medical License number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_