2024 ITALY PERFORMANCE TOUR
THE SUTHERLAND WINDS

MEDICAL AUTHORIZATION, RELEASE AND WAIVER AGREEMENT

Full name of Participant (as it appears on legal document or passport): _____

I hereby give my consent and authorization ("Authorization") to allow representatives of The Sutherland Winds, World Projects and/or World Projects affiliates or representatives, if any, attending the 2024 Italy Performance Tour to seek any necessary medical treatment for myself (or my child) during the Performance Tour, and I hereby appoint said persons as my attorney in fact to authorize medical treatment on my (or my child's) behalf (hereafter referred to as "Authorized Persons"). Authorized Persons may obtain medical treatment from physicians, dentists, staff, technicians and/or nurses on my (or my child's) behalf and may authorize the use of ambulances, paramedics, hospitals, and other medical facilities, and may authorize performance of any diagnostic procedures, treatment procedures, operative procedures, and x-ray treatment which these medical professionals determine are necessary. I authorize the hospital or medical facility to dispose of any specimen or tissue taken from the participant. I understand that I alone am responsible for the cost of any medical treatment provided for any reason, and that I alone am responsible for any and all consequences arising from or related to such medical treatment.

On behalf of myself, my heirs and my assigns, I hereby release and waive any and all claims related to my medical treatment against Authorized Persons, including but not limited to the selection of any medical, professional, or course of treatment, any authorization given or refused, any consent, failure to provide consent or measures taken or not taken to obtain medical treatment, or failure to obtain prior authorization or any other procedures required by any insurer that I may have. I understand that no person authorized to provide information or authorization is obliged to obtain medical treatment for me (or my child) or to transmit medical information to any person for any reason, and that this authorization and medical history is for my own convenience. This authorization does not create any rights or obligations against any Authorized Persons, and I agree to waive any claims that I may now have, ever had, or will have, and release, indemnify, defend, and hold harmless any Authorized Persons against any such claims, injuries, deaths, damages, causes of action, and liabilities, including requests for expenses and reasonable attorneys' fees, arising from or related to this Authorization.

I affirmatively state that I am (or my child is) fit to participate in the Performance Tour, and I know of no medical condition that would prevent my (or my child's) full and complete participation in the Performance Tour. I understand that the rigors of travel present unexpected circumstances and opportunities for injury and disease, and that I (or my child) will take all reasonable measures to protect and minimize exposure to injury and/or disease. I (or my child) will take adequate precautions to have an ample supply of any and all legally prescribed drugs and medications with me (or a group leader) during the course of the Performance Tour, and will take appropriate arrangements to ensure that I am (or my child is) able to receive medical treatment. I (or my child) will not consume any illegal substance during the course of the Performance Tour. I (or my child) will alert the tour group leader immediately in the event I (or my child) feel(s) ill or am (is) injured in any respect.

SECTION 1542. GENERAL RELEASE. A GENERAL RELEASE DOES NOT EXTEND TO CLAIMS WHICH THE CREDITOR DOES NOT KNOW OR SUSPECT TO EXIST IN HIS FAVOR AT THE TIME OF EXECUTING THE RELEASE, WHICH IF KNOWN BY HIM MUST HAVE MATERIALLY AFFECTED HIS SETTLEMENT WITH THE DEBTOR.

This Medical Authorization, Release, and Waiver Agreement shall be governed by the laws of the State of California, exclusive of its conflict of laws provisions. Any dispute between the Parties arising out of this Agreement shall be submitted to final and binding arbitration in the City of Walnut Creek, California, USA, under the Commercial Arbitration Rules and Mediation Procedures and the Supplementary Procedures for Consumer-Related Disputes of the American Arbitration Association then in effect, upon written notice and demand of any Party therefor. The arbitration shall be conducted by one (1) arbitrator, in the English language. Any arbitration award rendered shall be binding, final and conclusive upon all parties, and judgment thereon may be entered in any Court having jurisdiction thereof. The prevailing party shall be entitled to recover its costs and reasonable attorney's fees from the other party.

I swear that the foregoing is true and correct, and that this medical release was signed by me (as an adult participant) OR a parent or legal guardian (if participant is under the age of 18).

_____

Signature of Participant or Parent/Guardian on behalf of minor participant

Relationship to Participant: _____ Date: _____

NOTE: This Medical Authorization Release and Waiver Agreement Must Be Filled Out Completely and Signed by Parent or Guardian if Participant is Under the Age of 18.

THE SUTHERLAND WINDS
MEDICAL HISTORY

Name of Participant (as it appears on legal document or passport): _____

Participant's Date of Birth: _____

MEDICAL HISTORY

All statements concerning my medical history, insurance information and emergency contacts in the medical history that follows are current, accurate, and complete (use additional sheets if necessary). I understand that I am required to carry a complete medical history on my person at all times during the course of the Performance Tour. The following information is a full and correct statement of my medical history:

1. Identify any allergies, including allergies to medications:

   _____

   Are any of these allergies' life threatening? YES NO If yes, which one(s): _____

   Do you carry an epi-pen at all times? YES NO
2. Identify any special medical conditions: _____

   _____
3. Identify any prescription or over-the-counter drugs you are taking and how many times a day you take them:

   _____
4. Identify the date of your last tetanus shot, or any other relevant vaccinations:

   _____
5. Please include any dietary restrictions / preferences you may have:

   _____
6. Identify the name, address, e-mail, and telephone number of your physicians, dentists, or any other medical professionals, hospitals, or facilities having pertinent information concerning your medical history:

   a. _____

   b. _____

   c. _____
7. Please list three (3) emergency contacts:

   Name **Relationship** **Phone**

   a. _____

   b. _____

   c. _____

Medical Insurance Information

8. Identify the name of your health care insurer: _____
9. Identify the name of the subscriber of the plan: _____
10. Participant Number/Group Code: _____
11. Address and telephone number of the insurer: _____
12. Identify any requirements for seeking pre-approval from your medical carrier for medical treatment overseas:

    _____

I swear that the foregoing is true and correct, and that this medical history was signed on _____.

Signature of Participant or Parent/Guardian on behalf of minor participant: _____

Relationship to Participant: _____

NOTE: This Medical History Must Be Filled Out Completely and Signed by Parent or Guardian if Participant is Under the Age of 18.

If any additional information concerning the traveler's medical history would be pertinent in an evaluation by medical professionals, please initial here _____ and use a separate page for submitting additional information.