

Required for all Volunteers under the age of 18

Connecticut Mission of Mercy Free Dental Clinic *Under 18 Volunteer Waiver and Release Form*

I, the undersigned volunteer, desire and agree to volunteer for the Connecticut Mission of Mercy Free Dental Clinic.

I understand and agree as follows:

1. I, my personal representatives, heirs, assigns and anyone else entitled to claim through me, hereby waives any right of recovery, and waives, releases, holds harmless and forever discharges the Connecticut Mission of Mercy Free Dental Clinic, the Connecticut State Dental Association, the Connecticut Foundation for Dental Outreach, their officers, trustees, officials, employees and agents, and other volunteer dental service providers from liability related to the Undersigned, arising from any and all injury to persons and damage to property, and further agrees and undertakes to indemnify, hold harmless and defend the Connecticut Mission of Mercy Free Dental Clinic, the Connecticut State Dental Association, Connecticut Foundation for Dental Outreach from and against any and all claims, damages, actions, liability and expenses including attorney's fees and other professional fees in connection with bodily injury including death, personal injury and/or damage to property arising from or out of the Undersigned's activities and participation in volunteer services at the above Connecticut Mission of Mercy Free Dental Clinic.
2. I further acknowledge and agree that the Connecticut Mission of Mercy Free Dental Clinic, Connecticut State Dental Association, Connecticut Foundation for Dental Outreach does not assume any responsibility whatsoever for any property of the Undersigned and the Undersigned shall not hold the Connecticut Mission of Mercy Free Dental Clinic, Connecticut State Dental Association, Connecticut Foundation for Dental Outreach liable for any loss or damage to same.
3. I understand and acknowledge that the Connecticut Mission of Mercy Free Dental Clinic does not carry or maintain and expressly disclaims responsibility for providing any health, medical or disability insurance. I understand and acknowledge that I am to obtain my own insurance coverage.
4. I grant the Connecticut Mission of Mercy Free Dental Clinic, Connecticut State Dental Association, Connecticut Foundation for Dental Outreach and their agents the right to use without payment or consideration of any kind, my picture, voice and other reproductions of my physical likeness, in connection with advertising or publicizing Connecticut Mission of Mercy services and its activities in all forms of media in perpetuity.
5. I undertake to perform said services as a Volunteer without compensation and that, in performing said services, I acknowledge that I am not acting as an employee of the Connecticut Mission of Mercy Free Dental Clinic, Connecticut State Dental Association, or the Connecticut Foundation for Dental Outreach.
6. In compliance with the HIPAA Privacy Act: I further agree to hold in confidence all personal and protected health information I may overhear or come in contact with during and following the Connecticut Mission of Mercy Free Dental Clinic.

By signing below, I hereby state that I have read, understood and agree to all information stated above.

Volunteer Name (Please Print): _____

Volunteer Signature: _____ Date: _____

Name of Guardian (Please Print): _____ Relationship: _____

Signature of Guardian: _____ Date: _____