

**Koinonia of Upper New York
Young Mens/Womens co-ed KOINONIA Application**

AUTHORIZATION FOR MEDICAL TREATMENT FORM

Candidate's Printed Name: _____ **Birth Date:** _____

Parent/Guardian Printed Name: _____
Relationship to Candidate (*Circle one*): **Parent** **Guardian**

Parent/Guardian

Home Phone: (_____) _____ **Cell Phone:** (_____) _____ **Work Phone:** (_____) _____

Authorization for Medical Treatment

This release and consent gives KOINONIA leadership personnel permission to take my child to the nearest available medical facility and have any necessary emergency treatment administered.

I understand that every effort will be made to contact me. However, in case of emergency, if I cannot be reached, I hereby give KOINONIA permission to act on my behalf in seeking medical treatment by qualified personnel for my child in the event that such treatment is deemed necessary or advisable for my Candidate health, safety and welfare. I release KOINONIA and all medical providers from liability in acting on my behalf in this regard in rendering such medical treatment.

In an emergency, you may contact the person(s) below in the event that a parent/guardian cannot be reached:

Name: _____ **Home Phone:** (_____) _____ **Cell Phone:** (_____) _____

Name: _____ **Home Phone:** (_____) _____ **Cell Phone:** (_____) _____

Comments regarding my candidate's *medical history, allergies (food, medication, environmental) or drug reactions, etc.*, which may be needed in the case of any emergency treatment: _____

Medications: (Any/All Medications must be in their original containers. Use additional pages as needed.)

<u>Medication Name</u>	<u>Usage/Indication</u>	<u>Dosage</u>	<u>Schedule</u>

I have read and understand the Authorization for Medical Treatment information. To my best knowledge, the information I provide is correct and complete.

Parent/Guardian

Signature (Required): _____ **Date:** _____

Candidate Signature: _____ **Date:** _____

****If Candidate is emancipated, proof must be provided prior to event.**

All forms must be completed in full for Candidate to participate in the KOINONIA Weekend.

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PARENT/GUARDIAN RELEASE OF LIABILITY AND CONSENT FORM

Please Print

Dates and Location of Event: _____

Candidate's Name: _____ **Birthdate:** _____

Address: _____
(Street) (City) (State) (Zip)

Home Phone (_____) _____ **Cell Phone** (_____) _____

Release of Liability

I understand that participating in KOINONIA activities is a privilege. In consideration of this privilege, I release KOINONIA, including its directors, volunteers, employees and agents from and against any liability or claims for any loss, costs, damages, or injuries (including reasonable attorneys' fees and expenses) in any way arising from their participation in the KOINONIA Weekend.

I understand that my child may participate in a number of activities. I understand that there are certain risks associated with any activity; I will assume responsibility for these risks, whether known or unknown to me at this time. This release is also intended to include all claims of my family, estate, heirs, personal representative or assigns.

If I am under 18, my parent or guardian, by signing below, also consents to my release and he or she agrees that this release shall be binding upon him or her as my parent or guardian as to me and my estate, heirs, personal representatives and assigns. My parent or guardian also promises, by signing below to defend, indemnify and hold KOINONIA harmless from any claim asserted by me against KOINONIA, including its directors, volunteers, employees and agents, if I should repudiate this release after obtaining adulthood.

Consent

I have read and understand the Release of Liability information and consent to all indicated herein.

**Parent/Guardian
Signature (Required):** _____ **Date:** _____

Candidate Signature: _____ **Date:** _____

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INSURANCE INFORMATION

Candidate's Printed Name: _____ **Birth Date:** _____

Health Insurance Co: _____ Group No: _____

Phone Number: (____) _____ Subscriber I.D. #: _____

Insured under whose name? _____

Candidate's Physician: _____ Phone (____) _____

Note to Candidates not Currently Insured

- KOINONIA reserves the right to subrogation if it is later determined that personal medical insurance was in place.
- KOINONIA is compliant with the Health Insurance Portability and Accountability Act (or HIPAA).

I understand that my personal insurance will be primary coverage for any accident and that KOINONIA's policy does not cover illness.

"KOINONIA is a Christian faith based experience meant to encourage a young Christian with their ongoing walk with the Lord. Any Candidate of the weekend experience should be aware that there may be moments of intense personal introspection and reflection. We ask that in signing this form, you have disclosed to the leadership any information that may be beneficial to the team, to support continued growth in faith and allow us to be in tune to any subjects that may be of a sensitive nature to the individual. All information that is shared is considered confidential and will not be shared with any one outside of the KOINONIA team and leadership personnel."

I have read and understand the Insurance information, and consent to all indicated herein. To my best knowledge, the information I provide is correct and complete.

Parent/Guardian Signature: _____ **Date:** _____
(Required) Relationship to Candidate (*Circle one*): **Parent** **Guardian**

Candidate Signature: _____ **Date:** _____

***If Candidate is emancipated, proof must be provided prior to event.*

All forms must be completed in full for Candidate to participate in the KOINONIA Weekend.