

**KOINONIA MINISTRIES at WNCC
MASTER PERMISSION/WAIVER FORM**

Name of Child: _____

Parent/Legal Guardian(s): _____

Address: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Child's age: _____ D.O.B: _____

It is my understanding that participating in programs and activities of the Koinonia Ministry and WNCC is a privilege. Prior to participation, I acknowledge there are certain risks associated with the activities including, by way of example, physical injury due to activity related accidents, physical injury due to transportation-related accidents, illness, or even death. There may be other risks inherent in these activities of which I may not be presently aware.

By signing this Permission/Waiver Form, I expressly warrant that the child named above is capable of withstanding the physical and mental demands **of the YAS activities that will take place in the 2009-2010 school year,(we will also need specific parental consent for every future activity.)** I also expressly assume all risks of the child participating in the activities. I further release Koinonia Ministries and WNCC, its staff, leaders, employees, volunteers and agents from any claim my child may have against them as a result of injury or illness incurred during the course of participation in the activities. This release of liability is intended to cover all claims that members of the child's family or estate, heirs, representatives, or assigns may have against Koinonia or WNCC, or its staff, leaders, employees, volunteers or agents.

I further agree to indemnify and hold harmless Koinonia Ministries and WNCC and its staff, leaders, employees, volunteers, or agents from any and all claims arising from any participation in its activities and programs, or as a result of injury or illness of my child during such activities.

I recognize there may be occasions where the child named above may be in need of First Aid or emergency medical treatment as a result of an accident, illness, or other health condition or injury. I do hereby give permission for agents of Koinonia Ministries of the WNCC to seek any needed medical attention or treatment for the child named above, including hospitalization, if in the opinion of the agent such need arises and I cannot be reached. In doing so, I agree to pay all fees and costs arising from this action to obtain medical treatment. I give permission for attending physician(s) and other medical personnel to administer any needed medical treatment, including surgery, and again, I agree to pay for the medical treatment.

Special Needs or Concerns: _____

Allergies: _____

Medical Conditions: _____

Medical Insurance Co. _____

Medical Insurance # _____

Primary Insurance Carrier: _____

Place of Employment & Phone # _____

Name and Phone # for emergency Contact if parents can't be reached:

Please list any medication your child is currently taking (prescription or over the counter):

Signature of Parent/Legal Guardian

Date

Print Name of Parent/Legal Guardian