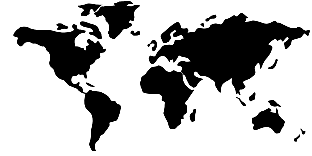
DIVINE WT BUFFALO 2018

A ministry of Koinonia Christian Fellowship Inc.



CONSENT FOR MEDICAL TREATMENT &
RELEASE AND HOLD HARMLESS AGREEMENT FORM

WHEREAS, I __________________________________ wish to be a member of the World Team missions trip to Buffalo, New York, USA, and, whereas certain circumstances and situations may occur resulting in (my child's, my need for medical care and treatment, and further resulting in my inability to give personal consent for such care or treatment,

1) THEREFORE, **I** ______________________________ being of legal age, *authorize Koinonia Christian Fellowship World Teams*, or any leader of *Koinonia Christian Fellowship World Teams* to act on my behalf should I be unable to do so and give consent to reasonable medical care and treatment, including but not limited to diagnostic test, x-ray examination, anesthesia, surgery, disposal of severed tissue, or hospital care on my behalf.

2) Any consent by *Koinonia Christian Fellowship World Teams* shall have the same force and effect as if I gave personal consent.

3) I certify that I have obtained health coverage with:

Company: ______________________________ Policy #: __________________with no territorial limitation, including foreign countries, which will provide health coverage for (my child, myself) for the duration of this said mission, including accidental death or dismemberment. I understand that no health coverage is provided by *Koinonia Christian Fellowship World Teams.*

4) I am aware that serious illness requiring return by air ambulance could cost more than $10,000.00 and that there is no coverage for such service by *Koinonia Christian Fellowship World Teams.* I agree that I am solely responsible for any expenses that may arise from my child's return by air ambulance or any other extraordinary means.

5) I hereby release hold harmless Koinonia Christian Fellowship World Teams from their liability with my participation in this activity. I further indemnify Koinonia Christian Fellowship World Teams, its officers, trustees, agents, and employees, from financial responsibility for my life and medical fees/premiums incurred pursuant to this consent.

Applicant's Signature: ____________________________________ Date: ____________

Applicant's Name (please print)____

Health Card number of applicant: ____