



## **Koinonia Adult Consent Waiver Form: (Confidential )**

(To be handed to Koinonia staff on arrival, prior to commencement of Activities.)

Group Name: \_\_\_\_\_

Participant Name: \_\_\_\_\_

I the participant give my consent to participate in the recreation activities provided by Koinonia. I am aware that elements of this program can be emotionally and physically demanding. I understand that certain obvious and / or inherent risks and dangers exist in the activities they will participate in.

These risks include falls from height, objects falling from above, trips and falls, falls from equipment, collisions between persons or persons and objects, pedestrians and or traffic accidents, drowning, getting lost, weather effects, contact with native animals and others.

I acknowledge that while Koinonia Ministries Ltd, its staff and others will make every reasonable effort to teach the participants sound outdoor technique and to minimise exposure to known risks, all hazards and dangers with these activities cannot be foreseen and may be beyond the control of Koinonia, its staff and others.

I recognise that the training provided by the staff is not sufficient to equip participants to carry out the activity without supervision by a trained instructor.

I have read all the program description and the gear list supplied and will endeavour to ensure the participant attends with all terms listed

I authorise Koinonia, its staff and others to obtain medical assistance that is deemed necessary and I agree to pay all medical expenses incurred on behalf of the participant.

The participants health is such that the activities planned will in no way aggravate any present condition. If in any doubt I will seek medical advice prior to the attendance of the participant.



Does the participant suffer from any of the following:

<b><i>Drug related allergies</i></b>	<b><i>Yes / No.</i></b>	
<b><i>Environmental Allergies</i></b>	<b><i>Yes / No.</i></b>	
<b><i>Conditions requiring medication</i></b>	<b><i>Yes / No.</i></b>	
<b><i>Recent illness or Injury</i></b>	<b><i>Yes / No.</i></b>	
<b><i>Emotional or Behavioural Disorders</i></b>	<b><i>Yes / No.</i></b>	
<b><i>Hearing Problems</i></b>	<b><i>Yes / No.</i></b>	
<b><i>Respiratory Problems</i></b>	<b><i>Yes / No.</i></b>	
<b><i>Swimming Status</i></b>	<b><i>Strong / Average /Poor</i></b>	
<b><i>Other</i></b>		

**Dietary Requirements: If you have a food allergy please complete below details. (15% Surcharge Applies)**

Please tick the box(s) that apply.

- |   |  |  |   |
|---|--|--|---|
| <input type="checkbox"/> Peanut Allergy           | <input type="checkbox"/> Tree Nut Allergy              | <input type="checkbox"/> Egg Allergy     | <input type="checkbox"/> Milk/Dairy Allergy |
| <input type="checkbox"/> Seafood Allergy          | <input type="checkbox"/> Sesame Allergy                | <input type="checkbox"/> Coeliac Disease | <input type="checkbox"/> Soy Allergy        |
| <input type="checkbox"/> Fish/Shellfish Allergy   | <input type="checkbox"/> Sesame Allergy                | <input type="checkbox"/> Vegetarian      | <input type="checkbox"/> Vegan              |
| <input type="checkbox"/> Gluten/Wheat Intolerance | <input type="checkbox"/> Other (Please Specify): ..... |  |   |

1. Are you able to have small amounts of the allergens you have listed above?  YES  NO
2. Are you able to have foods which carry the warning "may contain traces of..."?  YES  NO
3. Will you be providing your own food?  YES  NO *(Please specify)*

.....  
 4. Please provide any other information in relation to your food allergy.  
 .....

I understand that the Koinonia makes every attempt to identify ingredients that may cause allergic reactions for those with food allergies. I understand that while Koinonia is able to take every reasonable effort to avoid the allergens listed, even when they have been disclosed. In prepared food, it is impossible for Koinonia to provide any guarantee that the participant will not come into contact with the listed allergen or residues during the stay. The participant understands that it is a requirement that anyone with a known food anaphylaxis carry an Epipen with them at all times whilst at Camp Koinonia. I understand that the Group Leader/Teacher of the visiting group is responsible for ensuring that a person trained in issuing Epipen or other auto injector of adrenaline is in attendance with the visitor with food allergies to administer the medication as required.

Signed \_\_\_\_\_ Name \_\_\_\_\_

Date of Birth of participant \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Last Tetanus Booster \_\_\_\_/\_\_\_\_/\_\_\_\_

Health Fund \_\_\_\_\_

Medicare Number \_\_\_\_\_ Exp Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Emergency Contact Name : \_\_\_\_\_

Emergency Contact Phone: \_\_\_\_\_

Group Name: \_\_\_\_\_