

Youth & Christian Education Ministry Teams
Association of the Church of God of Southern California/Nevada
1901 Palo Verde Ave. Long Beach, CA. 90815 (562) 596-8437

Application for Adult Counselor

Name: _____ Male: _____ Female: _____
Church Name: _____ City: _____
Home Address: _____
City: _____ Zip Code: _____
Home Phone: _____ Cell/Work Phone: _____
Birthday: ____/____/____ E-mail Address: _____

I am applying to help as an adult counselor/chaperone for the following activity/activities of the Association of the Church of God of So. California and So. Nevada: (Application must be completed for each event separately and submitted to the Association office prior to event)

____ Kids' (children's) Kamp Event Date: _____ 30 Hour Famine Event Date: _____
____ Jr./Sr. High Camp Event Date: _____ Spring Rally Event Date: _____
____ Other: _____ Event Date: _____

Please use this section to describe your experience in ministry with youth and children:

This form is to be signed by the Senior Pastor of your church and by the Chairperson of your governing church board to verify that **both national criminal** and **state sexual misconduct** background checks have been conducted upon the applicant named on this form, with no records for sexual misconduct found, and that the applicant is eligible to work with minors.

Signature of Senior Pastor: _____ Date: _____
Signature of Board Chair: _____ Date: _____
Signature of Applicant: _____ Date: _____

Emergency Treatment Consent:

I agree and consent to having the staff members and/or counselors, under whose auspices the activity is conducted, and any other worker who has been approved as a guardian for this activity, to secure any medical care or treatment that may be necessary during the entire outing, including the trip to and from our destination for me. I further assume all responsibility for any decisions made, and the emergency care or treatment so secured by or for myself.

Applicant's Signature _____ Date _____

Do you have hospitalization insurance? ☐ Yes ☐ No

If yes, Name of Insurance Company _____

Policy Identification Number _____ Group Number _____

Doctor's Name _____ Phone Number _____

Emergency Phone Numbers and/or pager or cell phone:

Home _____ Work _____ Other _____

About You: Are there any habits, medications, allergies, special diets or needs, etc. that we may need to know about?
