

Youth & Christian Education Ministry Teams  
*Association of the Church of God of Southern California/Nevada*

425 Sierra Madre Villa Ave Pasadena, CA 91107

(877) 360-5025

Application for Adult Counselor

Name: \_\_\_\_\_ Male: \_\_\_\_\_ Female: \_\_\_\_\_

Church Name: \_\_\_\_\_ City: \_\_\_\_\_

Home Address: \_\_\_\_\_

City: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell/Work Phone: \_\_\_\_\_ Shirt Size: \_\_\_\_\_

Birthday: \_\_\_/\_\_\_/\_\_\_ E-mail Address: \_\_\_\_\_

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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: \_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

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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: \_\_\_\_\_

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**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?

\_\_\_\_\_