



MENTORING PARTICIPANT AGREEMENT, RELEASE AND ASSUMPTION OF RISK

Mentoring Budget: Your monthly mentoring package includes up to \$45 for both your child and the mentoring therapist to participate in typical activities, which help to introduce your child to new activities and or skills. It should be understood however, that the client may become interested in or we might recommend activities which may necessitate additional fees. Some examples include memberships to sporting programs and facilities or equipment and supplies. In such cases, these fees will be paid directly to the vendor and will remain separate from your relationship with Coyote Coast.

Please Initial _____

Travel time: On occasion, the monthly allotment included in your mentoring package will be exceeded in order to accommodate special activities (*Anything over 30 minutes per session*). In those cases, we will inform you that we will charge you hourly for additional travel time at a rate of \$50/hour.

Please Initial _____

Outside Outfitters: On occasions where your child participates in mentoring activities with an outfitter outside of Coyote Coast, parents will be asked to sign the outfitter's release and assumption of risk and to provide a copy of their driver's license for authentication of their signature on the release and assumption of risk form.

Please Initial _____

Health Insurance: Coyote Coast requires that all participants have their own health insurance. Please complete this section completely so that we will have information concerning your insurance coverage. It is your responsibility to make sure your insurance will cover you for the duration of the program.

Student's Name: _____

Name and Address of Person under Whose Name the Policy is Carried:

Policy Holder's Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Insurance Company Information:

Company Name: _____ Policy Number: _____ Group

Number: _____ Agreement Number: _____



Coyote Coast

YOUTH AND FAMILY COUNSELING, INC.
A LICENSED CLINICAL SOCIAL WORK GROUP

*The Coyote Coast
Activities Program*

Address Where Claims Must Be Submitted:

Contact Name: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

If Group Insurance, Give Name of Group (employer, union or association through which the student is insured)

Name: _____

Parent Permission to Treat:

_____ has my permission to participate in Coyote Coast Program(s) and Course(s). I hereby authorize Coyote Coast, its designees and agents to stand in loco parentis and authorize any necessary medical care or treatment should I be unavailable to render such consent for my minor child myself. I either have appropriate insurance or, in its absence, agree to pay all costs of rescue and/or medical services as may be incurred on my/our behalf. In addition, I have completed a Coyote Coast Medical Information Form for the above named minor child and certify that all of the information contained on the Medical Information Form is accurate and complete. This Medical Information Form may be photocopied and its content shared with Program staff as necessary. In addition Coyote Coast has permission to obtain a copy of my child's health record from providers who treat my child and these providers may talk with the program's staff about my child's health status.

Signature of participant or parent/guardian if participant is under 18:

Name (please print): _____

Signature: _____ Date: _____