CONSENT FOR SERVICE

This form should be completed only for adults receiving services from Karis Disability Services**.** For those who do not have the capacity to sign consent, a family/designate signature is required. If the person supported does not have a family/designate, support from the Office of the Public Guardian and Trustee should be sought. Note: Employees of Karis Disability Services must not sign the consents.

Name of Person Supported: _____

Service Initiation Date: _____

1. CONSENT FOR SERVICE

I consent to receiving service (which may include supports to engage in community life, experience inclusion and relationships, enjoy meaningful activities, and pursue personal growth) from Karis Disability Services.

☐ Initials of Person or Designate/Guardian ☐ Initials of Witness

2. CONFIDENTIALITY

I understand that Karis Disability Services commits to respecting my rights to confidentiality in principle and practice, including both the written and electronic material kept on file and the verbal material disclosed as part of planning or service provision. I also understand that, to maintain this level of confidentiality, information will only be shared or released in compliance with Karis Disability Services policy or subject to a court order.

☐ Initials of Person or Designate/Guardian ☐ Initials of Witness

3. LIABILITY

I understand that Karis Disability Services commits to providing service that is free from abuse, negligence, or wilful misconduct. I also understand that there are potential risks associated with the decisions that I make every day. While Karis Disability Services commits to helping me to understand these risks, I understand that I choose to take some risks in order to live the life that I choose to live, and that I will not hold Karis Disability Services, its volunteers, employees, or contractors responsible for damages, loss, or injuries associated with these risks, other than those associated with acts of abuse, negligence, or wilful misconduct.

☐ Initials of Person or Designate/Guardian ☐ Initials of Witness

4. EXPOSURE TO COMMUNICABLE DISEASE

I understand that Karis Disability Services may support people who may have a communicable disease (e.g., Hepatitis) at the same location where I receive support. I understand that Karis Disability Services will take precautions to prevent the spread of communicable disease and I will participate in preventative practices as required.

☐ Initials of Person or Designate/Guardian ☐ Initials of Witness

5. EMERGENCY MEDICAL TREATMENT

If any emergencies should arise, I understand Karis Disability Services will attempt to contact my designated emergency contact person. If my designated emergency contact person cannot be reached, I hereby authorize Karis Disability Services to seek urgent or emergency medical treatment. I understand that I may be responsible for any expenses incurred in obtaining medical care, including the costs of transportation.

☐ Initials of Person or Designate/Guardian ☐ Initials of Witness

6. USE OF PHOTOGRAPHS, FILMS, AUDIO, OR VIDEO

Karis Disability Services sometimes uses photos, film, audio or video in an effort to tell people about what Karis Disability Services does and the objectives of the organization. These may be used in brochures, posters, and videos, or other promotional or educational productions (either in print or online) about Karis Disability Services. Karis Disability Services always strives to portray people in a positive light, and adheres to its privacy policies when using photos, film, audio or video. I understand that this decision will not affect my services in any way.

☐ I give consent to Karis Disability Services to use pictures, audio or videos of me for purposes related to the non-profit educational and promotional objectives of the organization. These images, audio files and videos become the property of Karis Disability Services and may be disposed of in any manner and at any time Karis Disability Services chooses. I agree that Karis Disability Services may use the images, audio and video without receiving payment or compensation in any form.

☐ I do NOT give consent to Karis Disability Services to use pictures, audio or videos of me for purposes related to the non-profit educational and promotional objectives of the organization.

☐ Initials of Person or Designate/Guardian ☐ Initials of Witness

The signatures below are an acknowledgement of all of the consents initialed on this form.

Printed Name of Person or Designate/Guardian	Signature of Person or Designate/Guardian	Date
Printed Name of Witness	Signature of Witness	Date