ARCHDIOCESE OF CINCINNATI
PERMISSION, RELEASE AND MEDICAL POWER OF ATTORNEY (rev. 11-2016)
(PLEASE PRINT)

1. I, the parent or lawful guardian of _____(the "child/ children"), give permission for my child to participate in the activity described on the *Activity Information* form (the "Activity") and release from all liability and indemnify the Archdiocese of Cincinnati (the "Archdiocese"), the Archbishop of Cincinnati (the "Archbishop"), both individually and as trustee for the Archdiocese of Cincinnati, and all parishes and schools within the Archdiocese, and their respective officers, agents, representatives, volunteers, and employees from any and all liability, claims, judgments, cost and expenses, including attorneys' fees, arising out of any injury or illness incurred by my child while participating in or traveling to or from the Activity and further agree not to bring or prosecute or allow to be brought or prosecuted (including but not limited to prosecution through subrogation) in my name, or on behalf of my Child, any claims, lawsuits or actions against the Archbishop, the Archdiocese, and their respective officers, agents, representatives, volunteers and employees.
2. I further understand that my Child's/Children's participation in the Activity is purely voluntary and is a privilege and not a right, and that my Child/Children, and I on behalf of my Child/Children, agree to my Child's/Children's participation in the Activity in spite of the risks.
3. I agree to instruct my child/children to cooperate with the Archbishop or his agents in charge of the activity.
4. I appoint the Archbishop or his agents who are acting as leaders of the Activity as my attorney in fact to act for me in my name and my behalf, in any way that I would act if I were personally present, with respect to the following matters if any injury, illness or medical emergency occurs during the activity or related travel:
   (i) To give any and all consents and authorizations to any physicians, dentist, hospital or other persons or institutions pertaining to any emergency medications, medical or dental treatments, diagnostic or surgical procedures or any other emergency actions as our attorney shall deem necessary or appropriate for the best interest of the Child/Children.
   (ii) I understand that the agents of the Archbishop will make a reasonable attempt to contact me as soon as possible in the event of a medical emergency involving my child/children.
5. This power of attorney shall lapse automatically upon completion of the activity and related travel.
6. I agree that the Archbishop or his agents may use my child's/children's portrait or photograph for promotional purposes, website and office functions and use social media and technology to communicate to my child/children regarding ministry related activities.
   ☐ Give Permission ☐ DO NOT Give Permission
7. This acknowledgement and release is intended to be as broad and inclusive as permitted by the law of the State of Ohio, and if any portion hereof is declared invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect. This acknowledgement and release shall be construed in accordance with the laws of the State of Ohio, except for the choice of law provisions thereof.

I have carefully read and understand and accept the terms and conditions stated herein and acknowledge that this Permission, Release and Medical Power of Attorney shall be effective and binding upon me, my Child/Children, and my own and my Child/Children personal representative or estate, assigns, heirs, and next of kin and that I have signed this agreement of my own free will.

Signature of Parent or Guardian _____ Date _____ / _____ / _____

Home Address _____ City _____ Zip _____

Place of Employment _____ Phone: (w)_____

Work Address _____ City _____ Zip_____

Phone: (h)_____ (cell)_____ (c) _____

Emergency Contact _____ Phone (w) _____ (h) _____

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Medical Information – Completed by Parent or Guardian – PLEASE PRINT

Child's Name	Birth Date	Social Security # *	Allergies/Medications/Chronic Conditions (e.g. epilepsy, diabetes)

Medical Insurance Co. _____ Policy No. _____

Member's Name _____ Phone: (h) _____ (w) _____

Member's Birth Date _____/_____/_____ Member's Social Security # * _____

Family Doctor _____ Phone _____

***Social Security numbers are optional, but SHOULD NOT be emailed due to Personal Identifiable Information Act.**
(Please note that some hospitals WILL NOT treat without it.)

School Year – 2017-2018