

ARCHDIOCESE OF CINCINNATI
PERMISSION, RELEASE AND MEDICAL POWER OF ATTORNEY (rev. 6-2006)

1. I, the lawful parent or guardian of ___ *please list below _____ (the "child"), give permission for my child to participate in the activity described on the *Activity Information* form and release from all liability and indemnify the Archbishop of Cincinnati ("the Archbishop"), both individually and as trustee for the Archdiocese of Cincinnati and all parishes within the Archdiocese, and their officers, agents, representatives, volunteers, and employees from any and all liability, claims, judgments, cost or expenses, including attorney fees, arising out of any injury or illness incurred by my child while participating in or traveling to or from the activity.
2. I agree to instruct my child to cooperate with the Archbishop or his agents in charge of the activity.
- 3a. 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 consent 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.
 - (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.
- 3b. This power of attorney shall lapse automatically upon completion of the activity and related travel.
4. I agree that the Archbishop or his agents may use my child's portrait or photograph for promotional purposes, website and office functions.

I have carefully read this statement, and my signature acknowledges that I fully understand the content and meaning.

Signature of Parent or Guardian _____ Date _____
 Home Address _____ City _____ Zip _____
 Place of Employment _____
 Work Address _____ City _____ Zip _____
 Parent or Guardian Phone No. (w) _____ (h) _____
 Emergency Contact _____ Phone No. (w) _____ (h) _____

Medical Information – Completed by Parent or Guardian – Please print

Medical Insurance Co. _____ Policy No. _____
 Member's Name _____ Phone No. (h) _____ (w) _____
 Member's Birth date _____ Member's Soc. Sec. No. * _____
 Family Doctor _____ Phone No. _____

***LISTING OF PARTICIPANT(S) NAME(S) WITH DATE OF BIRTH**

Child's Name _____ D.O.B. _____ Child's Name _____ D.O.B. _____
 Child's Name _____ D.O.B. _____ Child's Name _____ D.O.B. _____
 Child's Name _____ D.O.B. _____ Child's Name _____ D.O.B. _____

Please list any allergies, medications or chronic conditions or other concerns and to which child each applies:

ACTIVITY INFORMATION

B. One-Time Activity

Holy Angels Religious Ed – Vacation Bible School – Holy Angels School -- \$15 / kid, \$30 / family

Starting/Ending Date and Time: June 12-16, 2017, 9am – 12 pm **Meeting Place:** Holy Angels Cafeteria

Activities Involved: Music, snack, story, games, crafts, final performance in church

Group Leader: Susan Anderson/Gerriann Hemmert **Telephone No.:** 937-498-0433