PSR Grades 1-6

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

1. I, the lawful parent or guardian of (1)_____, (Options for listing additional children follow) (2)_____ , (3)_____, (4)_____, (the "child (ren)"), give permission for my child (ren)to participate in the activity described on the *Activity Information* form and release from all liability and indemnify theArchbishop 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 (ren) while participating in or traveling to or from the activity.

2. I agree to instruct my child (ren) 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 (ren).

(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 (ren).

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 (ren)'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) _____

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Medical Information --- Completed by Parent or Guardian --- Please Print

Sections Provided for Additional Children If Needed

(1) Child's Name _____ Birth Date _____

Child's Soc. Sec. No. * _____

Allergies _____

Medications _____

Chronic Conditions (e.g. epilepsy, diabetes) _____

(2) Child's Name _____ Birth Date _____

Child's Soc. Sec. No. * _____

Allergies _____

Medications _____

Chronic Conditions (e.g. epilepsy, diabetes) _____

(3) Child's Name _____ Birth Date _____

Child's Soc. Sec. No. * _____

Allergies _____

Medications _____

Chronic Conditions (e.g. epilepsy, diabetes) _____

(4) Child's Name _____ Birth Date _____

Child's Soc. Sec. No. * _____

Allergies _____

Medications _____

Chronic Conditions (e.g. epilepsy, diabetes) _____

MEDICAL INFORMATION FOR ALL CHILDREN (list on separate sheet if an information differs)

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. _____

***Social Security Number is optional. Please note that some hospitals WILL NOT treat without it.**

ACTIVITY INFORMATION

Completed by Church Agency – Please Print

(As a convenience to parent(s) or guardian(s), a duplicate copy of this information may be attached so as to be retained by them; also any additional information may be attached to further inform them of specific scheduling details, additional activity information, etc.)

A. <u>On-Going Program</u>

Church Agency _____Holy Angels_____Program or Group ____PSR 1-6_____

Starting Date ___9/13/2017_____ Ending Date ____5/9/2018_____ Registration Fee __$35___

Usual Location ___Holy Angels School_____Usual day and time _____7 pm - Wednesday__

Routine Activities __Religious Education_____

Group Leader ____Susan Anderson_____ Telephone No. _____937-498-0433_____

Other Information _____

_____ Check here if any additional information is attached. (Note: any additional activity information e.g. schedule, list of specific activities, etc.) may be attached to further inform parents(s) or guardian(s).

*I understand that this medical / release form applies to all onsite PSR Classes and Activities. I also authorize this form to be used as a medical / release form for class trips to Chilly Jilly's or the Soup Kitchen, understanding that I will be notified in advance if the class plans to take a trip there.

_____ _____

Parent Signature Date