ARCHDIOCESE OF CINCINNATI K THRU 12TH GRADE
PERMISSION, RELEASE AND MEDICAL POWER OF ATTORNEY (REV. 7-2005)

(PLEASE PRINT)

1. I, the lawful parent or guardian of ______________________ (the "child/children), give permission for my child/children to participate in the activity 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 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.

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 ___ /___ /______

Address ______________________ City ______________ Zip __________

Place of Employment ______________________ Phone: (w) __________

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 number is optional; however, please note that some hospitals WILL NOT treat without it.**

School Year – __________