ARCHDIOCESE OF CINCINNATI
PERMISSION, RELEASE AND MEDICAL POWER OF ATTORNEY

1. **I, the lawful parent of guardian of_____ (the "child"), give permission for my child to participate in the activity described on the reverse 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.**
3. **a. 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 medication, medical or dentist 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.**

   b. The 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 and office functions. I have carefully read this statement, and my signature acknowledges that I fully understand the content and meaning.**

_____ _____ _____
Signature of parent **date** **phone**

Address _____ **City**_____**Zip**_____

Work Phone _____ **Cell** _____

Emergency Contact Name_____ **Phone** _____

Medical Information
Completed by Parent or Guardian- Please Print

Child's Name_____**Birth Date**_____

Allergies_____

Medications_____

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

Medical Insurance Co._____

Member's Name_____**Best daytime phone**_____

Family Doctor_____**Phone**_____

Church Agency- St. Joseph/St. Raphael Church Program or Group- _____
Starting Date- _____ Ending Date- _____
Registration Fee- _____

Usual Location- St. Joseph/Raphael grounds Usual Day and Time- _____
Routine Activities- _____
Group Leader- _____ Telephone No.- 323-7523
Other Information: _____
_____
Additional Activities- _____