

St. Augustine / St. Joseph Parish School of Religion
ARCHDIOCESE OF CINCINNATI K THRU 12TH GRADE
PERMISSION, RELEASE AND MEDICAL POWER OF ATTORNEY (REV. 2013)
(PLEASE PRINT - SEE REVERSE for ACTIVITY information)

1. I, the lawful parent or guardian of _____ (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 and schools within the Archdiocese (the "Archdiocese"), and their 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 officers, agents, representatives, volunteers and employees.
2. I further understand that my Child's participation is purely voluntary and is a privilege and not a right, and that my Child, and I on behalf of my Child, elect to participate in spite of the risks.
3. I agree to instruct my child 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: 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.
5. 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.
6. This power of attorney shall lapse automatically upon completion of the activity and related travel.
7. I agree that the Archbishop or his agents may use my child's portrait or photograph for promotional purposes, website and office functions and use social media and technology to communicate to my child regarding ministry related activities. (Facebook, texting, etc.)
8. 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 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) _____

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 # * _____
 (*Social Security number is optional. Note that some hospitals WILL NOT treat without it.)

Family Doctor _____ Phone _____

ACTIVITY INFORMATION

Completed by Church Agency - Please Print

A. On – going Program

Church: **St. Augustine/St. Joseph Parish Cluster**

Program: **Religious Education Program**

Starting Date: **9/4/19** Ending Date: **5/28/2020**

Registration Fee: 1st and 2nd each child: **\$75**, 3rd and 4th each child **\$50**, Family maximum **\$250**

Location: **St. Augustine/St. Joseph Parish Center 89 N. Lincoln St. Minster OH 45865**

Usual day and time: **Per Minster Local Schools Wednesday and Thursday Release Time Schedule**

Transportation: **Church Bus**

Routine Activities: **Grade school students attend Mass on Wednesdays, and a weekly catechetical session and fieldtrips/special events as scheduled.**

Also including Sundays am and pm, also Wednesday activities 8 am for High School Students at the Religious Education/Parish Center

Group Leaders: **Therese Brown and John Schmiesing**
(CRE K-8) (CRE 9-12, YM 7-12)

Phone No. **419.628.3434**