Name_____

RELEASE & MEDICAL INFO

Church of the Ascension 2025 Woodman Dr, Kettering OH 45420 www.ascensionkettering.org **Sept, 30. 2018, Jan.6 March31, 2019**

Dear parents or legal guardians,

This form will serve as permission, release, medical power of attorney, and photo use for Scene 75 Outing This form will be in effect and held on file for the program year dated below. However, activities sponsored by other churches/organizations or events held off-site may require additional forms. It is your responsibility to notify the Youth Office with any necessary updates.

Ongoing Activity: **Ascension Youth Ministry (Middle School & High School)** Date: Sept. 30, 2018, Jan. 7 & March 31, 2019
Location: **Scene 75** 6196 Poe Ave, Dayton, OH 45414
Contact Person: **Jeanne Fairbanks, Coordinator of Youth Ministry** Emergency No: **Office 253-5171 x111/ Cell 937-5724291**

ARCHDIOCESE OF CINCINNATI
PERMISSION, RELEASE AND MEDICAL POWER OF ATTORNEY

1. I, the lawful parent or 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, judgements, 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.

(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.

Parent/Guardian Signature_____ Date _____/_____/_____

Home Address_____ City_____ Zip_____

Parent E-mail_____ Youth E-mail_____

Phone (H)_____ (W)_____(C)_____

Youth Cell _____ Youth School_____HS year of graduation_____

Emergency Contact_____ Phone (H)_____(W)_____(C)_____

MEDICAL INFORMATION -- Completed By Parent/Guardian -- Please Print
This section need only be completed once per year unless updates are necessary

Child's Name_____ Birthdate_____/_____/_____

Allergies & Recommended Treatment_____

Medications, Times, Dosages_____

Medication may be administered by (circle all that apply): My child chaperones

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

Medical Insurance Co._____ Policy Number_____

Member's Name_____ Hm Phone _____ Wk Phone _____

Member's Birthdate_____/_____/_____

Family Doctor _____ Phone _____