**CHIILD'S NAME___________________________________ GRADE_________**

## ARCHDIOCESE OF CINCINNATI
## PERMISSION, RELEASE AND MEDICAL POWER OF ATTORNEY (rev. 11-2016)

1. I, the parent or lawful guardian of ______________________________(the õchildö), give permission for my child to participate in Our Lady of Sorrows PSR program for the 2018-2019 academic year and release from all liability and indemnify the Archdiocese of Cincinnati, the Archbishop of Cincinnati (Archbishop Dennis Schnurr), both individually and as trustee for the Archdiocese of Cincinnati, and all parishes and schools within the Archdiocese, and their respective officers, agents, representatives, volunteers, and employees from any and all liability, claims, judgments, cost and expenses, including attorneysø 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 respective officers, agents, representatives, volunteers and employees.

2. I further understand that my Childøs participation in the Activity is purely voluntary and is a privilege and not a right, and that my Child, and I on behalf of my Child, agree to my Childøs participation in the Activity 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:

(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.

5. This power of attorney shall lapse automatically upon completion of the activity and related travel.

6. I agree that the Archbishop or his agents may use a photograph, video or other likeness of my child for promotional purposes, website and office functions and use social media and technology to communicate to my child regarding ministry related activities.

7. 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 and understand and accept the terms and conditions stated herein and acknowledge that this Permission, Release and Medical Power of Attorney shall be effective and binding upon me, my Child, and my own and my Childøs personal representative or estate, assigns, heirs, and next of kin and that I have signed this agreement of my own free will.

Signature of Parent or Guardian ____________________________________________ Date ____/____/______

Home Address ______________________________________ City ____________________ Zip ________

Place of Employment ______________________________________________________________

Work Address ______________________________________ City ____________________ Zip ________

Parent or Guardian Phone No. (w) _____________ (h) _______________ (c) _______________

Emergency Contact ____________________________ Phone No. (w) _____________ (h) _______________
(c) _________________

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***PLEASE FILL OUT BOTH SIDES***

**Medical Information — Completed by Parent or Guardian — Please Print**

Childøs Name ____________________________________________ Birth date ____/____/_______

Childøs Soc. Sec. No. *______________________________

Allergies ______________________________________________________________________

Medications ____________________________________________________________________

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

Medical Insurance Co.____________________________________ Policy No. ____________________

Memberøs Name ___________________________ Phone No. (h) ____________ (w) _____________

Memberøs Birth date ____/____/_______ Memberøs Soc. Sec. No. * _______________________________

Family Doctor ___________________________________ Phone No. ___________________________

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

(See *Activity Information* form below)

**ACTIVITY INFORMATION**
**Completed by Church Agency - Please Print**

Church Agency **Our Lady of Sorrows** Program or Group **PSR Program**

Starting Date **September 19, 2018** Ending Date **May 5, 2019** Registration Fee **$70.00 1 child, $120.00 max**

Usual Location **OLOS Church campus, various locations throughout** Usual Day & Time **Sundays 9:00-10:15 AM**

Routine Activities **Classroom activities that are necessary to teach PSR curriculum**

Group Leader **Christine Baumgardner, Rel. Ed. Coordinator** Telephone No. **513-539-8061 or 513-418-1371**

Signature of Parent or Guardian______________________________ Date______________

***PLEASE FILL OUT BOTH SIDES***