ARCHDIOCESE OF CINCINNATI
PERMISSION, RELEASE AND MEDICAL POWER OF ATTORNEY (rev. 6-2006)

Release and indemnification agreement, medical power of attorney, and medical information for all Youth Events/Activities, sponsored by St. Ignatius Parish, from September 1st, 2019 through September 1st, 2020.

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 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.

(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.

Signature of Parent or Guardian _____ Date ____/____/____

Home Address _____ City _____ Zip _____

Place of Employment _____

Work Address _____ City _____ Zip _____

Parent or Guardian Phone No. (w) _____ (h) _____(cell)----------
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Emergency Contact _____ Phone No. (cell) _____ (h) _____

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Medical Information — Completed by Parent or Guardian — Please Print

Medical Insurance Co._____ Policy No. _____

Member's Name _____ Phone No. (h) _____ (w) _____

Member's Birth date ____/____/____ Member's Soc. Sec. No. * _____

Family Doctor _____ Phone No. _____

Child's Name _____ Birth date ____/____/____

Child's Soc. Sec. No. *_____

Allergies _____

Medications _____

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

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

(Additional children can be listed on the back)

Medical Information — Completed by Parent or Guardian — Please Print

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

If your child has a special need, please request our "Special Needs" Form at saintipsr@gmail.com

Child's Name ______________________________ Birth date ____/____/________

Child's Soc. Sec. No. *______________________

Allergies ______________________________

Medications ______________________________

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

Child's Name ______________________________ Birth date ____/____/________

Child's Soc. Sec. No. *______________________

Allergies ______________________________

Medications ______________________________

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

Child's Name ______________________________ Birth date ____/____/________

Child's Soc. Sec. No. *______________________

Allergies ______________________________

Medications ______________________________

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

Child's Name ______________________________ Birth date ____/____/________

Child's Soc. Sec. No. *______________________

Allergies ______________________________

Medications ______________________________

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

Child's Name ______________________________ Birth date ____/____/________

Child's Soc. Sec. No. *______________________

Allergies ______________________________

Medications ______________________________

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

(See *Activity Information* form)