

**ARCHDIOCESE OF CINCINNATI**

**PERMISSION, RELEASE AND MEDICAL POWER OF ATTORNEY (rev. 7-2005)**

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, 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 permission, release and medical power of attorney shall be deemed valid for all activities of the **St. Gertrude Parish Youth Ministry Program**, as published by the St. Gertrude Parish Youth Ministry Program or in the parish bulletin, for a period of one year from the date consent is granted.

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 \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Phone: (h) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Place of Employment \_\_\_\_\_ Phone: (w) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone: (w) \_\_\_\_\_ (h) \_\_\_\_\_

\*\*\*\*\*

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

Child's Name \_\_\_\_\_ Birth date \_\_\_\_\_

Child's Social Security # \* \_\_\_\_\_

Allergies \_\_\_\_\_ Chronic Conditions (e.g. epilepsy, diabetes) \_\_\_\_\_

Medications \_\_\_\_\_

Medical Insurance Co. \_\_\_\_\_ Policy No. \_\_\_\_\_

Member's Name \_\_\_\_\_ Phone: (h) \_\_\_\_\_ (w) \_\_\_\_\_

Member's Birth Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Member's Social Security # \* \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_

\*Social Security number is optional; however, please note that some hospitals WILL NOT treat without it.

**ST. GERTRUDE YOUTH MINISTRY ACTIVITY INFORMATION  
ARCHDIOCESE OF CINCINNATI, OHIO  
PERMISSION, RELEASE & MEDICAL POWER OF ATTORNEY**

1. I, the lawful parent or guardian of \_\_\_\_\_ (the "child"), give permission for my child to participate in activities 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 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 activities.
  
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 activities 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 permission, release and medical power of attorney shall be deemed valid for all activities of the **St. Gertrude Parish Youth Ministry Program**, as published by the St. Gertrude Parish Youth Ministry Program or in the parish bulletin, for a period of one year from the date consent is granted.
  
- 3c). If any change occurs in the information provided by parent or guardian with respect to emergency contacts or medical information, the appropriate agent will be provided with written notification of such changes as soon as possible.
  
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 or Guardian \_\_\_\_\_ Date    /    /

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Place of Employment \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Phone: (w) \_\_\_\_\_ (h) \_\_\_\_\_ Social Security # (optional) \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone: (w) \_\_\_\_\_ (h) \_\_\_\_\_

\*\*\*\*\*

**Medical Information – Completed by Parent or Guardian – PLEASE PRINT**

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Allergies \_\_\_\_\_

Medications \_\_\_\_\_

Chronic Conditions (e.g. epilepsy, diabetes) \_\_\_\_\_

Medical Insurance Co. \_\_\_\_\_ Policy No. \_\_\_\_\_

Member's Name \_\_\_\_\_ Phone: (h) \_\_\_\_\_ (w) \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_