St. Vivian Office of Religious Education

This form shall be kept for the **2016-2017** School Year. This form will provide all the necessary medical/emergency information regarding your child, which will be used in the event of an emergency while your child is participating in a program/event.

Programs/events include, but are not limited to: Sacramental preparation (Confirmation, Reconciliation, First Eucharist), PSR, service activities, Vacation Bible School, and retreats.

Archdiocese of Cincinnati RELEASE AND MEDICAL POWER OF ATTORNEY *(rev. 8-2013)*

1. I, the lawful parent or guardian of _____(the "child"), give permission for my child to participate in the activity(s) described above 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:
   (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 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.)
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 Child's 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 Phone:_____ Work Phone: _____ Cell Phone:_____

Address_____ City/ST_____ Zip_____

Emergency Contact (Other than Parent)_____

Emergency Contact's: Home Phone:_____ Cell Phone:_____

Medical Information

Child's Name_____ Date of Birth_____Soc. Sec. #_____

Allergies_____Medications_____

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

Family Doctor_____ Phone _____

Hospital Preference_____

Medical Insurance Company_____Phone:_____

Policy Number_____ Group Number_____

Policy Holder's Name_____