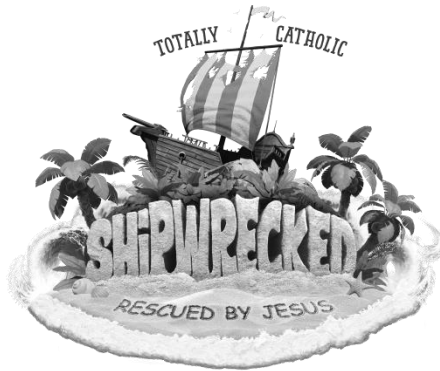


# BLESSED SAINTS PASTORAL REGION VBS 2018 (ST. BARTHOLOMEW/ST. VIVIAN)



## WE NEED CASTAWAY CREW MEMBERS FOR OUR VBS!

### Volunteer Form

We need many volunteers to make VBS successful.

**We need volunteers June 25<sup>th</sup> – June 29<sup>th</sup> from 8:30 am – 12:30 pm at St. Bartholomew Church** (Program runs from 9 am to 12 pm.)

If you are an adult or student who will be in the 6<sup>th</sup> grade or above in the fall and are able to volunteer, please fill out this form and return it to Amy Staubach at the St. Bartholomew office or Julie Zinser at St. Vivian office.

If you are under 18 please have a parent fill out the release on the back.

Name \_\_\_\_\_ Phone Number: \_\_\_\_\_

Email \_\_\_\_\_ T-shirt size \_\_\_\_\_

#### **Desired Job** (Place a check next to desired job)

Crew Leader

Pre-School Helper

Games Helper

Craft Helper

Drama Team

Music Leader

Snacks Helper

Registration



#### **Volunteer Training Sessions:**

Tuesday June 19<sup>th</sup> from 7 – 9 pm

Sunday June 24<sup>th</sup> 1pm – 3 pm.

All sessions will take place in St. Bartholomew Parish Office.

Decorating and Set up will take place the week prior as well as on Sunday June 24<sup>th</sup>. Check email for exact times as we get closer.

\* All adult volunteers must be Virtus compliant. A special training session will be scheduled as needed. Please let Amy or Julie know if needed.

**ARCHDIOCESE OF CINCINNATI**  
**PERMISSION, RELEASE AND**  
**AUTHORIZATION TO SEEK MEDICAL TREATMENT (rev. 09-2017)**

1. I, the parent or lawful guardian of \_\_\_\_\_ (the "child"), give permission for my child to participate in the activity described on the *Activity Information* form (the "Activity") and release from all liability and indemnify the Archdiocese of Cincinnati (the "Archdiocese"), the Archbishop of Cincinnati (the "Archbishop"), both individually and as trustee for the Archdiocese, 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 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 respective officers, agents, representatives, volunteers and employees.

2. I further understand that my Child's 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 Child's 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 to seek medical treatment of my child in the event of any injury, illness or medical emergency occurs during the activity or related travel. 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. I  agree  do not 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.

6. 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 Authorization to Seek Medical Treatment 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   /  /  

Signature of Witness: \_\_\_\_\_ Witness Name (please print): \_\_\_\_\_

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

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

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

Parent or Guardian Phone No. (cell): \_\_\_\_\_ ; (other Phone No.): \_\_\_\_\_

Emergency Contact Phone No. (cell): \_\_\_\_\_ ; (other Phone No.): \_\_\_\_\_

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

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

Allergies \_\_\_\_\_

Medications \_\_\_\_\_

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

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

Member's Name \_\_\_\_\_ Phone No. (h) \_\_\_\_\_ (w) \_\_\_\_\_

Member's Birth date   /  /  

Family Doctor \_\_\_\_\_ Phone No. \_\_\_\_\_