Junior High Retreat June 26-27 10:00 – 3:00 each day $25/person

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

1. I, the parent or lawful guardian of _____ 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 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 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 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 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 Address_____
Place of Employment & Phone _____
Parent or Guardian Name & Phone No. (w) (h) (c)_____
Emergency Contact Name & Phone No. (w) (h) (c)_____

Best number to contact you during the retreat in the event of an emergency: _____

Medical Information — Completed by Parent or Guardian — Please Print

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

Child's Soc. Sec. No. *_____

Allergies _____

Does your child carry an epi-pen and if so, does he/she know how to administer it? _____

Medications _____

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

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. _____

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

(See *Activity Information* form below)

T shirt size: Please circle one:

youth extra small youth small youth medium youth large youth extra large
adult extra small adult small adult medium adult large adult extra large

ACTIVITY INFORMATION
Completed by Church Agency - Please Print

(As a convenience to parent(s) or guardian(s), a duplicate copy of this information may be attached so as to be retained by them; also any additional information may be attached to further inform them of specific scheduling details, additional activity information, etc.)

B. <u>One-Time Activity</u>

Church Agency Spiritual Center of Maria Stein

Activity: Junior High Retreat

Location: Spiritual Center of Maria Stein – 2365 St. Johns Road, Maria Stein, OH 45860

Cost: $25

Date and Time June 26 & 27 10:00 a.m. –3:00 p.m. Meeting Place: Spiritual Center

Activities Involved: Mass, games, food, prayer, laughter, inspiring talks, more prayer, FUN!!!!

Type of Transportation: Youth need to be dropped off and picked up at The Spiritual Center at the designated times.

Group Leader: Robin Goettemoeller
Phone No. 419-305-2738 or 419-925-7625

Page 2 of 2 Signature of Parent/Guardian _____ ***Date*** _____

PLEASE RETURN THIS FORM ALONG WITH $25/child
BY JUNE 19 to register for the Junior High Retreat!