PERMISSION, RELEASE AND AUTHORIZATION TO SEEK MEDICAL TREATMENT

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, the Diocese of Toledo (the "Diocese"), the Bishop of Toledo (the "Bishop"), both individually and as trustee for the Diocese, and all parishes and schools with the Archdiocese and Diocese, 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, the Diocese, the Bishop, and their respective officers, agent, representatives, volunteers and employees.

2. I further understand that my child's participation in the Activity is purely voluntary and nis 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 and Bishop or their agents in charge of the Activity.

4. I appoint the Archbishop, the Bishop or their 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 and Bishop 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 and Bishop or their agents may us my child's portrait or photograph or video 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 state 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 _____ Printed Witness Name _____

Home Address _____ City, State Zip _____

Place of Employment _____ Address _____

Parent or Guardian Phone (cell) _____ Other Phone No. _____

Emergency Contact Phone (cell) _____ Other Phone No. _____

Child's Name _____ Date of Birth _____

Physician's Name _____ Phone No. _____

Allergies or Medical Conditions _____