

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

Release and indemnification agreement, medical power of attorney, and medical information for the Bethlehem Bazaar, sponsored by St. John the Baptist December 13<sup>th</sup> from 3:00 – 9:00 pm

1. I, the parent or lawful guardian of \_\_\_\_\_ (the “child”), give permission for my child to participate in all Youth Events/Activities sponsored by St. John Neumann Church, Cincinnati, 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 I  agree  do not agree that the Archbishop or his agents may 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 \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name of Parent or Guardian (print): \_\_\_\_\_ Parent Email: \_\_\_\_\_

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

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

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

Parent or Guardian Phone No. (w) \_\_\_\_\_ (h) \_\_\_\_\_ (c) \_\_\_\_\_

Emergency Contact \_\_\_\_\_

Phone No. of Emergency Contact: (w) \_\_\_\_\_ (h) \_\_\_\_\_ (c) \_\_\_\_\_

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

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

Child’s Soc. Sec. No. \* \_\_\_\_\_ School & Grade: \_\_\_\_\_

Allergies \_\_\_\_\_

Medications \_\_\_\_\_

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

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

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

Member’s Birthdate \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Member’s Soc. Sec. No. \* \_\_\_\_\_

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

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