

OFF-SITE& ONE-TIME ACTIVITY RELEASE & MEDICAL INFO

St. John Neumann, 12191 Mill Rd, Cincinnati, OH 45240, (513) 742-0953

ACTIVITY: Leap Day Celebration
LOCATION: St. John Neumann Parish
START DATE/TIME: Feb. 29th 7:00 PM
END DATE/TIME: Feb. 29th 9:00 PM
TRANSPORTATION: Parent drop off and pick up
TYPE OF ACTIVITIES: Food, Games and Prayer

COST: no cost
EMERGENCY PHONE: 513-742-0953
MEETING PLACE: SJN Youth Room
LEADER: Elizabeth Montgomery
EMAIL: emontgomery@isoc.net

*****PARENTS: KEEP TOP for your records, RETURN BOTTOM of form*****

**ARCHDIOCESE OF CINCINNATI—PERMISSION,
RELEASE AND MEDICAL POWER OF ATTORNEY**

**Event:Leap Day Celebration
Date: Feb. 29, 2008**

1. I, the lawful parent or guardian of _____ (the "child"), give permission for my child to participate in the activity 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 within the Archdiocese, and the officers, agents, representatives, volunteers, and employees from any and all liability, claims, judgments, cost or expenses including attorney fees, arising out of any injury or illness incurred by my child while participating in or traveling to or from the activity.
2. I agree to instruct my child to cooperate with the Archbishop or his agents in charge of the activity.
- 3.(a) 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 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 my 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.
- 3.(b) This power of attorney shall lapse automatically upon completion of the activity and related travel.
4. I agree that the Archbishop of his agent may use by child's portrait or photograph for promotional purposes and office functions.

I have carefully read this statement, and my signature acknowledges that I fully understand the content and meaning.

Parent/Guardian signature _____ Date ____/____/____

Home Address _____ City _____ Zip _____

Parent or Youth Email Address _____

Phone (H) _____ (W) _____ (Cell) _____

Emergency Contact _____ Phone (H) _____ (Cell) _____

MEDICAL INFORMATION - - Completed by Parent/Guardian - Please Print

Child's Name _____ Birthdate ____/____/____ *Child's Soc. Sec. # _____

Allergies & Recommended Treatment _____

Medications, Times, Dosages _____

Medication may be administered by (circle all that apply): My child chaperones

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

Medical Insurance Co. _____ Policy Number _____

Member's Name _____ Hm Phone _____ Wk Phone _____

Family Doctor _____ Phone _____