

ARCHDIOCESE OF CINCINNATI PERMISSION, RELEASE & MEDICAL POWER OF ATTORNEY (rev. 2005)

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 their 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.

3a. 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.

3b. This power of attorney shall lapse automatically upon completion of the activity and related travel.

4. I agree that the Archbishop or his agents may use my child's portrait or photograph for promotional purposes, website and office functions.

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

I have all the necessary information about activities involved.

Signature of Parent or Guardian _____ Date ____/____/____

Address _____ City _____ Zip _____

Phone: (w) _____ (h) _____ (c) _____

Emergency Contact _____ Phone: (c) _____ (h) _____

ALSO Signature of Participant (if 18 or over) _____ Date ____/____/____

Student's School _____

Current Grade/Year (please circle) 6th 7th 8th 9th 10th 11th 12th

Medical Information — Completed by Parent or Guardian — Please Print

Child's Name _____ Birthdate ____/____/____

Allergies/Medications _____

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

Please check one: If requested, my child may be given these non-prescription products (circle each approved) Tylenol Advil Alavert Tums Pepto-Bismol Other _____

NO MEDICATION of any type may be given to my child unless the situation is life threatening, and emergency treatment is required.

Family Doctor _____ Phone _____

Medical Insurance Co. _____ Policy # _____

Members Name _____ Phone: (h) _____ (w) _____

Member Place of Employment _____

Participant's SSN# _____ Member SSN# _____

*Social Security Number is optional; however, please note that some hospitals WILL NOT treat without it.

ACTIVITY INFORMATION -- Completed by Church Agency - Please Print

Church Agency St. John Neumann Activity JrHi Retreat Location Sts. Peter & Paul in Reading

Cost *early bird special* \$20 if forms and fees in by Dec. 5th; *regular registration* \$30 if forms and fees in after Dec. 5th

Starting Date and Time 7pm December 11, 2009 Ending Date and Time 12pm December 12, 2009 Transportation self

Group Leader Elizabeth Montgomery Phone. 513-742-0953 x11 Emergency No. 937-409-6503 (Elizabeth's cell

Activities Involved food, friends, games, small groups, prayer