

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

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

Activity: HS Winter Retreat Location: Glen Helen Outdoor Education Center, Yellow Springs OH

Start Date/time: Fri. Feb. 12 6:00 PM End date/time: Sun. Feb. 14 2:00 pm

Transportation: Caravan from SJN - Parent drivers needed Activities: Talks, icebreakers, small group discussions

Group Leader: Elizabeth Montgomery Telephone no.: 742-0953 x11 c: 937-409-6503

PARENTS: KEEP TOP for your records, Return BOTTOM of Form

ARCHDIOCESE OF CINCINNATI/ST. JOHN NEUMANN PARISH Event: **HS Winter Retreat**
PERMISSION, RELEASE AND MEDICAL POWER OF ATTORNEY (rev. 7-2005) Date: Feb. 12-14, 2010

1. I, the lawful parent or guardian of _____ (the "child"), give permission for my child to participate in the activity described on the reverse 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.

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

Home Address _____ City _____ Zip _____

Phone:(H) _____ (C) _____ (W) _____

Youth Cell _____ Youth School _____ HS year of graduation _____

Emergency Contact _____ Best phone # to reach: _____

Medical Information — Completed by Parent or Guardian — Please Print

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

Allergies _____ Medications _____

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

Medical Insurance Co. _____ Policy No. _____

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

Family Doctor _____ Phone _____

_____ **I can Drive youth to Glen Helen on Friday** (_____ # passengers w/seatbelts)

_____ **I can Drive youth back from Glen Helen on Sunday** (_____ # passengers w/seatbelts)