ARCHDIOCESE OF CINCINNATI PERMISSION, RELEASE AND MEDICAL POWER OF ATTORNEY (rev. 7-2005)

1. I, the lawful parent or guardian of _____give permission for my child to participate in the Prepare Affair Event at St. Martin of Tours Parish on Saturday, November 12, 2016and release from all liability and indemnify the Archbishop of Cincinnati 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.

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

Signature of Parent/Guardian_____ Date:_____

Address_____City_____ Zip _____

Emergency Contact _____ Relation: _____

Phone: (w)_____ (h)_____ (cell/other)_____

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Medical Information — Completed by Parent or Guardian — Please Print

Child's Name _____ Birth date _____/ _____/ _____
Child's Soc. Sec. # *_____
Allergies _____
Medications _____
Chronic Conditions (e.g. epilepsy, diabetes) _____
Medical Insurance Co. _____ Policy No. _____
Member's Name _____ Phone: (h) _____ (w) _____
Member's Birth date _____/ _____/ _____ Member's Soc. Sec. # *_____
Family Doctor _____ Phone _____

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