

**ACTIVITY INFORMATION**

**Activity:** All Religious Education and Youth Ministry Programs sponsored by St. John Fisher Parish

**Date:** July 1, 2011 thru July 31, 2012

**Location:** St. John Fisher Parish

**Contact Person:** Aimee Baer or Patti Sholtes

**Emergency Phone:** (513) 561-9431

**ARCHDIOCESE OF CINCINNATI  
RELEASE AND INDEMNIFICATION AGREEMENT AND MEDICAL POWER OF ATTORNEY**

1. I, the lawful parent or guardian of \_\_\_\_\_ (the "child"), give permission for my  
*(first and last name of child)*  
child to participate in any and all Religious Education Programs sponsored by St. John Fisher Parish including but not limited to the Summer Religious Education Program, nursery program, early childhood (preschool CCD), and sacramental preparation programs, 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, costs 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 and his agents 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 related travel:

(i) To give any and all consents and authorizations to any physician, 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.

(b) This power of attorney shall lapse automatically upon the 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 and office functions.

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

_____ Signature of Parent or Legal Guardian	_____ Date	_____ Home Phone	_____ Work Phone
_____ Address	_____ City	_____ Zip	
_____ Emergency Contact	_____ Relationship	_____ Phone	

**MEDICAL INFORMATION**

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Allergies \_\_\_\_\_

Current Medications and Dosage \_\_\_\_\_

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

Medical Insurance Company \_\_\_\_\_ Policy # \_\_\_\_\_

Member's Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_