

ACTIVITY INFORMATION

Church Agency: Ascension Religious Education Office

Program: Religious Education

Starting Date: Sept. 2011

Ending Date: May 2012

Usual Location: Ascension School (Gr. 8 – Youth Meeting Room/ WC-131)

Usual Day and Time: EC@Sun 10:30am; Gr. 1-5@Mon 4:15pm; Gr. 6-8@ Sun 9:45am or Mon 6:30pm

Routine Activities: Religious Education classes

Coordinator of RE: Susan Graham

Telephone No. 254-0622

Check here if any additional information is attached. Note: any additional activity information (e.g. schedule, list of specific activities, etc.) may be attached to further inform parent(s) or guardian(s).

**Archdiocese of Cincinnati
Permission, Release and Medical Power of Attorney**

Last Name _____

Address _____ City _____ Zip _____

Home Phone # _____

1. I, the lawful parent or guardian of (please list children's names) _____

give permission for my child to participate in Religious Education Classes 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, 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 or his agents in charge of the activity.
- 3. 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:
 - a. 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 dentist 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.
 - b. 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.
 - c. 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** ___/___/___

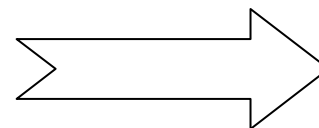
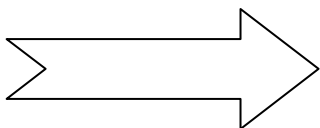
Work Phone: _____ **Cell Phone:** _____

Emergency contact _____ **Relationship** _____

(other than Parent)

Phone # of Emergency Contact _____

Please complete reverse



Medical Insurance Company _____ Policy No. _____

Member's Name _____

Family doctor Name _____ Phone _____

Dentist Name _____ Phone _____

**Medical Information to be completed by Parent or Guardian
(Please Print clearly)**

Family Name _____ Phone _____

Child's Name _____ Birth Date _____ Grade _____

Allergies _____

Medications _____

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

Child's Name _____ Birth Date _____ Grade _____

Allergies _____

Medications _____

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

Child's Name _____ Birth Date _____ Grade _____

Allergies _____

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