

**ACTIVITY INFORMATION**

Church of the Ascension, 2001 Woodman Drive, Kettering OH 45420  
RE Office 254-0622 School Office 254-5411

**ACTIVITY:** Grade 7 Confirmation Retreat **DATE:** Friday, Oct. 14, 2011 **COST:** ---  
**LOCATION:** Witzman Center **EMERGENCY PHONE:** 253-5171 x100 (Parish Office)  
**START TIME:** 8:00 a.m. **MEETING PLACE:** Witzman Center  
**END TIME:** 2:30 p.m. **MEETING PLACE:** Witzman Center  
**TRANSPORTATION:** Parent/School Bus **CONTACT:** Sue Graham **TEL:** 254-0622  
**OTHER INFORMATION:** Bring Confirmation binder and bible. Lunch provided for students and volunteers. Last name A-F, please bring a bag of cookies; G-M, please bring 2-liter bottle of soda/juice; N-R, please bring a bag of baby carrots/celery or grapes; S-Z please bring a bag of chips/snacks



**\*Detach & Return the Information Below this Line\***

**ARCHDIOCESE OF CINCINNATI --- PERMISSION,  
RELEASE AND MEDICAL POWER OF ATTORNEY (Rev. 1/97)**

**7<sup>th</sup> Gr Confirmation Retreat**

- 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 the 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.
- 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 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 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 completion of the activity and related
- 4. I agree that the Archbishop or his agent 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 the content and meaning.

\_\_\_\_\_  
**Signature of Parent or Guardian**                      **Date**                      **Phone**  
Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_ WorkPhone \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

**Parents Please Initial Accordingly:**

- \_\_\_\_\_ I HAVE a Medical Information form for my child ON FILE with the Ascension RE or School Office and all INFORMATION on the form IS ACCURATE and UP TO DATE.
- \_\_\_\_\_ I HAVE a Medical Information form for my child ON FILE with the Ascension RE or School Office BUT the INFORMATION NEEDS TO BE UP DATED as detailed below.
- \_\_\_\_\_ I DO NOT HAVE a Medical Information Card for my child ON FILE with the Ascension RE or School Office and have ACCURATELY COMPLETED the medical INFORMATION BELOW.

**MEDICAL INFORMATION** -- Completed By Parent or Guardian -- Please Print

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_\_  
Allergies \_\_\_\_\_  
Medications \_\_\_\_\_  
Chronic Conditions (e.g. epilepsy, diabetes) \_\_\_\_\_  
Medical Insurance Co. \_\_\_\_\_ Policy Number \_\_\_\_\_  
Member's Name \_\_\_\_\_ Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_  
Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_