

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

**Church of the Ascension** 2025 Woodman Dr, Kettering OH 45420 www.ascensionkettering.org

ACTIVITY: \_\_\_\_\_ COST: \_\_\_\_\_  
LOCATION: \_\_\_\_\_ EMERGENCY PHONE: \_\_\_\_\_  
START DATE/TIME: \_\_\_\_\_ MEETING PLACE: \_\_\_\_\_  
END DATE/TIME: \_\_\_\_\_ LEADER: \_\_\_\_\_ TEL: \_\_\_\_\_  
TRANSPORTATION: \_\_\_\_\_ EMAIL: \_\_\_\_\_  
TYPE OF ACTIVITIES: \_\_\_\_\_  
OTHER INFORMATION: \_\_\_\_\_

----- PARENTS: KEEP TOP for your records, RETURN BOTTOM of form -----

**ARCHDIOCESE OF CINCINNATI  
PERMISSION, RELEASE AND MEDICAL POWER OF ATTORNEY**

Event: \_\_\_\_\_  
Date: \_\_\_\_\_

- 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, judgements, 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.

Parent/Guardian Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_  
Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Parent or Youth Email Address \_\_\_\_\_  
Place of Employment \_\_\_\_\_  
Work Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_  
Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ (C) \_\_\_\_\_

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

Child's Name \_\_\_\_\_ Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  
Allergies & Recommended Treatment \_\_\_\_\_  
Medications, Times, Dosages \_\_\_\_\_  
Medication may be administered by (circle all that apply): My child chaperones  
Chronic Conditions (e.g. epilepsy, diabetes) \_\_\_\_\_  
Medical Insurance Co. \_\_\_\_\_ Policy Number \_\_\_\_\_  
Member's Name \_\_\_\_\_ Member's Birthdate \_\_\_\_/\_\_\_\_/\_\_\_\_  
Hm Phone \_\_\_\_\_ Wk Phone \_\_\_\_\_  
Family Doctor \_\_\_\_\_ Phone \_\_\_\_\_

\_\_\_ I can Drive/Chaperone ( \_\_\_ # passengers w/ seatbelts) OFFICE USE: Paid \_\_\_\_\_ Check # \_\_\_\_\_