EMERGENCY MEDICAL FORM
ARCHDIOCESE OF CINCINNATI
PERMISSION, RELEASE AND MEDICAL POWER OF ATTORNEY (rev. 6-2006)

1. I, the lawful parent or guardian of _____(the "child"), give permission for my child to participate in St. Andrew/St. Elizabeth Ann Seton Confirmation Activities and Formation 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 and schools within the Archdiocese (the "Archdiocese"), and their officers, agents, representatives, volunteers, and employees from any and all liability, claims, judgments, cost and expenses, including attorneys' fees, arising out of any injury or illness incurred by my child while participating in or traveling to or from the activity and further agree not to bring or prosecute or allow to be brought or prosecuted (including but not limited to prosecution through subrogation) in my name, or on behalf of my Child, any claims, lawsuits or actions against the Archbishop, the Archdiocese, and their officers, agents, representatives, volunteers and employees.

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:

(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.

4. This power of attorney shall lapse automatically upon completion of the activity.

5. I agree that the Archbishop or his agents may use my child's portrait or photograph for promotional purposes, website and office functions.

My signature acknowledge that I have carefully read and understand and accept the terms and conditions stated herein.

Signature of Parent or Guardian _____ Date ____/____/_____

Home Address _____ City _____ Zip _____

Place of Employment _____

Work Address _____ City _____ Zip _____

Parent or Guardian Phone No. (w) _____ (h) _____(c) _____

Emergency Contact _____ Phone No. (c) _____ (h) _____

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Medical Information — Completed by Parent or Guardian — Please Print

Child's Name _____ Birth date ____/____/_____

Allergies _____

Medications _____

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

Please List any learning difficulties. Is child on an IEP or 504 plan? _____

_____

Medical Insurance Co._____ Policy No. _____

Member's Name _____ Phone No. (h) _____ (w) _____

Member's Birth date ____/____/_____

Family Doctor _____ Phone No. _____