PLEASE "SAVE AS" A NEW DOCUMENT AND EMAIL COMPLETED THE FORM TO BETH KOCH <psr@ohiocatholic.org>

ARCHDIOCESE OF CINCINNATI
PERMISSION, RELEASE AND
AUTHORIZATION TO SEEK MEDICAL TREATMENT 2021-2022 (rev. 09-2017)

1. I, the parent or lawful guardian of ___________________________________**(the "child(children)**, give permission for my child to participate in the activity described on the *Activity Information* form (the "Activity") and release from all liability and indemnify the Archdiocese of Cincinnati (the "Archdiocese"), the Archbishop of Cincinnati (the "Archbishop"), both individually and as trustee for the Archdiocese, and all parishes and schools within the Archdiocese, and their respective 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 respective officers, agents, representatives, volunteers and employees.

2. I further understand that my Child's participation in the activity is purely voluntary and is a privilege and not a right and that my Child, and I on behalf of my Child, agree to my Child's participation in the Activity in spite of the risks.

3. I agree to instruct my child to cooperate with the Archbishop or his agents in charge of the activity.

4. I appoint the Archbishop or his agents who are acting as leaders of the Activity to seek medical treatment of my child in the event of any injury, illness, or medical emergency that occurs during the activity or related travel. 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.

5. **I [ ] agree [ ] do not agree** that the Archbishop or his agents may use my child's portrait or photograph for promotional purposes, website and office functions, and use social media and technology to communicate to my child regarding ministry-related activities.

6. This acknowledgment and release are intended to be as broad and inclusive as permitted by the law of the State of Ohio, and if any portion hereof is declared invalid, it is agreed that the balance shall, notwithstanding, continue in full legal force and effect. This acknowledgment and release shall be construed in accordance with the laws of the State of Ohio, except for the choice of law provisions thereof.

I have carefully read and understand and accept the terms and conditions stated herein and acknowledge that this Permission, Release, and Authorization to Seek Medical Treatment shall be effective and binding upon me, my Child, and my own and my Child's personal representative or estate, assigns, heirs, and next of kin and that I have signed this agreement of my own free will.

Signature of Parent or Guardian ____________________________________**Date** __ __ ____

____

Parent or Guardian Phone No. (cell): ________________; **(other Phone No.):** ________________.
__________________ **(Parent's/Guardian's Name)**

Emergency Contact Phone No. (cell): ________________; **(other Phone No.): (Parent/Guardian's/ Emergency contact name)** **Email address:**
Child's Primary Address

____
Address **City** **State** **Zip**
****

Medical Information — Completed by Parent or Guardian

1. Child's Name ____ Birth date ____/____/______

Allergies ____

Medications ____

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

Medical Insurance Co.____ Policy No. ______________

Member's Name __________________________________ Phone No. (h) ____________ (w) ________

Member's Birth date ____/____/__________

Family Doctor ____________________________________ Phone No. __________________________

2. Child's Name ____

Birth date ____/____/____

Allergies ____

Medications ____

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

3. Child's Name ___________ Birth date ____/____/____________

Allergies ____

Medications ____

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

ACTIVITY INFORMATION

Completed by Church Agency

(As a convenience to parent(s) or guardian(s), a duplicate copy of this information may be attached so as to be retained by them; also any additional information may be attached to further inform them of specific scheduling details, additional activity information, etc.)

Church Agency **St Angela Merici** _Activity **PSR**

Location **Daly Hall** Emergency No. **513-875-5020**

Starting Date and Time October 9, 2022, at 9 am

Ending Date and Time May 14, 2022, at 11 am Sundays only

Activities Involved: Sunday morning PSR activitie**s**

Group Leader **Beth Koch_** Telephone No. **513-875-5020 my cell 513-312-5526**

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