

**St. John the Evangelist Church
Office of Youth & Young Adult Ministry
Permission, Release, And Medical Power of Attorney Form 2011-2012
(Completed by Parent or Guardian, Please Print)**

Name _____ School _____

(If Lakota please specify East, West, Freshman, Ridge Jr., etc.)

Teen's Email _____

Home Phone _____ Parent's Email _____ Birthdate ___/___/___ Grade _____

This Permission, Release, and Medical Power of Attorney Form will cover all onsite and offsite activities of St. John the Evangelist Church, including Youth & Young Adult Ministry, and including transportation, from the date signed through Sept. 30, 2012. A separate registration form for each activity may also be required. Specific forms are available at the Office of Youth & Young Adult Ministry prior to each event. The phone number is 755-4972.

Please notify us if any information given below changes throughout the year. Thank you.

ARCHDIOCESE OF CINCINNATI
RELEASE AND INDEMNIFICATION AND MEDICAL POWER OF ATTORNEY

1. I, the lawful parent or guardian of _____ (the "child"), give permission for my child to participate in all St. John Youth & Young Adult Ministry activities, 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, 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. The powers and authority granted herein may be revoked by me by written notice delivered to the Archbishop or his agents who are then acting or who have previously acted hereunder. Without such written notice, this power of attorney shall not be affected by my disability, incapacity or adjudicated incompetence. This power of attorney shall lapse automatically at the end of above said time period.
4. I agree that the Archbishop or his agents may use my child's portrait or photograph, including digitally or electronically, for promotional purposes, office functions, including websites, and hereby release the Archbishop and his agents from any liability resulting from such use.

I have carefully read this statement, and my signature acknowledges that I fully understand its content and meaning.

_____	____/____/____	_____
Signature of Parent or Guardian	Date	Home Phone
_____	_____	_____
Print Name	Relationship	Cell/Emergency Phone

Address _____ City/State _____ Zip _____

Parent's Employment _____ Work Phone _____

Address _____ City/State _____ Zip _____

Medications _____

Allergies/Disorders/ _____

Chronic conditions (e.g. epilepsy, ADHD, diabetes) _____

Medical Insurance Company _____ Member Number _____

Member's Name _____ Home Phone _____ Cell/Emergency Phone _____

Child's Doctor _____ Phone _____ Any Other # _____

Other Emergency Contact _____ **Relationship** _____ **Phone** _____