

# Spring Retreat: Born Identity - March 2-4, 2012

## Release / Registration Form

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

- I, the lawful parent or guardian of \_\_\_\_\_ (the "child"), give permission for my child to participate in the activity described below 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 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.
- I further understand that my Child's participation is purely voluntary and is a privilege and not a right, and that my Child, and I on behalf of my Child, elect to participate in spite of the risks.
- I agree to instruct my child to cooperate with the Archbishop or his agents in charge of the activity.
- 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:
  - 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.
  - 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.
- This power of attorney shall lapse automatically upon completion of the activity and related travel.
- I agree that the Archbishop or his agents may use my child's portrait or photograph for promotional purposes, website and office functions.
- This acknowledgement and release is 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 acknowledgement 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 Medical Power of Attorney 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 \_\_\_\_/\_\_\_\_/\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Parent Email \_\_\_\_\_

Parent or Guardian Phone No. (h) \_\_\_\_\_ (w) \_\_\_\_\_ (c) \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone No. (h) \_\_\_\_\_ (c) \_\_\_\_\_

Student Signature (if over 18) \_\_\_\_\_

\*\*\*\*\*

Child's Name \_\_\_\_\_ Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_

Child's Soc. Sec. No. \* \_\_\_\_\_ Chronic Conditions (e.g. diabetes) \_\_\_\_\_

Allergies/Medications \_\_\_\_\_

Medical Insurance Co. \_\_\_\_\_ Policy No. \_\_\_\_\_

Member's Name \_\_\_\_\_ Phone No. (h) \_\_\_\_\_ (w) \_\_\_\_\_

Member's Birth date \_\_\_\_/\_\_\_\_/\_\_\_\_ Member's Soc. Sec. No. \* \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone No. \_\_\_\_\_

*\* Social Security Number is optional. Please note that some hospitals WILL NOT treat without it. \**

\*\*\*\*\*

### One Time Activity

Event Spring Retreat – Born Identity Activity Location Holy Spirit Center 5440 Moeller Ave. Emergency # 513-519-7042  
(Brad's Cell) Who: Open to all High Schoolers. Dates March 2-4, 2012 Time: 6pm on Fri., March 2 – 1:30pm on Sun., March 4  
Permission Slip Due: Feb. 24, 2012 (\$5 late fee after this date) Cost: \$60 – make checks payable to St. Event Leader:  
Brad Bursa Telephone No: 513-527-3975 Special Notes: If everyone could bring a drink and snack to share, it would be greatly  
appreciated. Definitive beginning and closing times are still being determined. We will mail out a letter with final details and to-bring  
list the week of the event. Please note that you should be dropped off, having already eaten dinner, at the HS Center. We will attend  
the 12:30pm Mass at St. Gertrude on Sunday – please invite your families and make sure they know to pick you up there.