ACTIVITY INFORMATION

Church Agency: Emmanuel Catholic Church/Immaculate H.E.A.R.T. Homeschool Co/op
Starting/Ending Date: Thursdays, September 2010 - May 2011
Usual Location: 149 Franklin St. Dayton Ohio 45402 937-228-2013
Usual Day and Time: Thursdays, 7:30 AM to 3:00 PM, Class times vary, special events outside of regularly scheduled classes.

Archdiocese of Cincinnati
Permission, Release and Medical Power of Attorney

Last Name ____

Address ______________________________ City ________________ Zip ____________

Home Phone # __________________________ Home Parish __________________________

1. I, The lawful parent or guardian of (please list children's names) ______________________________

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   give permission for my child to participate in Religious Education Classes described above, 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, representative, volunteers, and employees from any and all liability, claims, judgments, costs 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.
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 medial emergency occurs during the activity or related travel:
   a. 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 dentist 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.
   b. 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.
   c. 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 acknowledge that I fully understand the content and meaning.

Signature of Parent or Guardian ______________________________ **Date** ____/____/____

Work Phone: ______________________________ **Cell Phone** ____________________

Emergency Contact *(other than parent)*______________________________________

Phone# of Emergency Contact ____

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Medical Insurance Company ______________________________ **Policy No.**______________

Members Name ____

Family Doctor Name ______________________________ **Phone** ____________________

Dentist Name ______________________________ **Phone** ____________________

Refusal of Consent

I do not give my consent for emergency medical Treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the RE authorities to take no action or to:

Date: ________________________ Signature of Parent ____

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Medical Information to be completed by Parent or Guardian
(Please print clearly)

Child's Name ___________________________________ Date of Birth ______________ Grade _________

Allergies ____

Medications ____

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

Special Needs ____

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Child's Name ___________________________________ Date of Birth ______________ Grade _________

Allergies ____

Medications ____

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

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