

Guardian Angels Youth Ministry

2019-2020 Youth Events Release Form

ARCHDIOCESE OF CINCINNATI PERMISSION, RELEASE, AND MEDICAL POWER OF ATTORNEY (rev. 11-2016)

1. I, the parent or lawful guardian of _____ (the "child"), give permission for my child to participate in the activity described on the *Activity Information* portion (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 of Cincinnati, 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 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 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, elect to participate 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 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.
5. This power of attorney shall lapse automatically upon completion of the activity and related travel.
6. I agree that the Archbishop or his agents may use my child's portrait or photograph for promotional purposes (social media, website, office functions, etc.) and use social media and technology to communicate to my child regarding ministry related activities. (Facebook, texting, etc.)
7. 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.

Please Initial Each Item Below:

- I have (or will) read and am familiar with all program information including (but not limited to) website information, calendar, and the youth ministry handbook. _____
- I understand that any changes to this ministry or specific events will be communicated (to the best of the team's ability) well in advance. _____
- I understand that any other off-site, overnight, or other extraordinary events will not be covered by this form and that I will therefore need to sign and date an additional release (excluding contact/medical info which will be kept separately on file) for said events. _____

Child's Name: _____ Parent/Guardian Name: _____

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

Signature (if over 18) _____

Activity Information: On-Going Program

Church Agency: Guardian Angels Program: Middle School (6th-8th grade) and High School (9th-12th grade) Youth Ministry for 2019-2020 Starting Date: 07/01/19 Ending Date: 06/30/20 Registration Fee: None Usual Location: GA Campus, 6531 Beechmont Avenue, Cincinnati, OH 45230 Usual Day/Time: First Fridays 6:30 – 8:30pm, 3rd Saturdays/Sundays 7:00 – 9:00pm, Thursday evenings (High School) 7-8:30pm, other activities as detailed in handbook and website calendar Routine Activities: Speakers, Recreational Activities, Worship, Prayer, Games Group Leader: Bradley Barnes Contact Number: 513-624-3148 (office) 513-310-6949 (cell)

2019-2020 Contact Information – Please Print

Child Name _____ Parent/Guardian Name _____

Child School & Grade (2019-2020 year) _____

Home Address _____

City _____ State _____ Zip _____

Parent/Guardian Phone Number – Circle best and indicate if capable of receiving texts:

(Home) _____ (Work) _____ (Cell) _____

Emergency Contact _____ Phone No. _____

Parent Email _____ Youth Email _____

2019-2020 Medical Information — Completed by Parent or Guardian — Please Print

Child's Name _____ Birthdate _____

Child's Soc. Sec. No. * _____

Allergies _____

Medications _____

(Review & Initial) I understand that for longer events, any required medication – including over-the-counter – will need to be discussed and logged with youth ministry. _____

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

Medical Insurance Co. _____ Policy No. _____

Member's Name _____

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

Member's Birthdate _____ Member's Soc. Sec. No. * _____

Family Doctor _____ Phone No. _____

Signature of Parent/Guardian _____ Date _____

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