* COMPLETE BOTH SIDES *

ARCHDIOCESE OF CINCINNATI
PERMISSION, RELEASE AND MEDICAL POWER OF ATTORNEY

1. I, the lawful parent or guardian of _____(the "child"), give permission for my child to participate in the activity described on the reverse 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, judgements, 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. 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 acknowledges that I fully understand the content and meaning.

Signature of Parent/Guardian_____ Date _____

Address_____ City_____ Zip_____

Home Phone _____ Cell Phone _____

Place of Employment _____ Wk. Phone _____

Address_____ City_____ Zip_____

Emergency Contact_____ Phone (w)_____ (h)_____ (cell)_____

****

ACTIVITY INFORMATION

Completed by Church Agency - Please Print

(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.)

On-Going Program

Church Agency: St. Peter Parish Activity: Food Pantry worker

Location __Food Pantry -behind school_____ Emergency No. 937-237-2112 Cost ___NA____

Starting Date and Time __Saturday Aug 1, 2022 9:30 a.m._____

Ending Date and Time Saturday Aug 29 2023 12:00 pm

Meeting Place___Food Pantry_____ Type of Transportation (if any) _____N/A_____

Activities Involved: help with loading groceries into vehicles and other misc._____

Group Leader(s)____Donna Weed_____ Telephone No. 937-237-2112___

Other Information ___must bring this form in order to volunteer_____

_____ Check here if any additional information is attached. (Note: any additional activity information (e.g. schedule, list of specific activities, etc.) may be attached to further inform parent(s) or guardian(s).

* COMPLETE BOTH SIDES *

Medical Information / ORAL MEDICATION ADMINISTRATION RELEASE FORM
Completed by Parent or Guardian - Please Print

Child's Name _____ Birth Date _____
Last First MI

Child's Social Security # * _____

List any allergies: _____

List any Medications: _____

List any Chronic Conditions (e.g. epilepsy, diabetes): _____

Medical Insurance Co. _____ Policy No. _____

Member's Name _____ Phone(h)_____ (w)_____

Member's Birth Date ___/___/___ Member's Social Security # * _____

Family Doctor _____ Phone _____

** Social Security number is optional; however, please note that some hospitals WILL NOT treat without it. **

****

If your child is bringing medication(s), bring ONLY THE AMOUNT of medication needed for the event. List the type and specific instructions for administering it: _____

_____

If the Need Arises, Please Give My Child:

Tylenol _____ Ibuprofen _____ Aspirin _____ Nothing _____

TO: _____ RE: _____
Director of Religious Education Student

We/I the undersigned, the parent/foster parent/guardian of above student request that ORAL* medication be administered to our child in accordance with the instructions of our physician .

We understand that the administration of said medication is to be done under the supervision of a member of the Parish Staff. We/I further understand that the St. Peter personnel are not legally obligated to administer oral medication to any child. Therefore, I/we agree to hold the parish and its employees free from any and all responsibility for the results of such medication or the manner in which it is administered and to indemnify each of them against loss by reason of civil judgement arising out of these arrangements which may be rendered against them.

*Oral medication, for release, refers to medication in pill form only. Liquid medication that must be measured cannot be administered. Also, the Parish staff will not assume the responsibility for administering in injections, applying ointments, or changing dressings.
**Both parents must sign this release if they are living with or have custody of the child. If parents are separated and both still retain legal custody, both parents must sign. If children are in a foster home and placement is by an agency that holds custody, the agency must sign.

_____ _____
** signature of father date ** signature of mother date

_____ _____
address of parents home phone cell phone work phone

* * * * * To be completed by the Religious Education Office * * * * *

1. Person(s) authorized to administer medication for this student. Director of Religious Education to list.

_____ _____ _____

2. Director of Religious Education (DRE)_____ Date _____