**St. Paul Catholic Church, ARCHDIOCESE OF CINCINNATI**

**PERMISSION, RELEASE AND AUTHORIZATION TO SEEK MEDICAL TREATMENT** (rev. 09-2017)

**Family Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ School Year: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. I, the parent or lawful guardian of a) b) c) d)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (the “child/children”), give permission for my child/children to participate in the activity described on the *Activity Information* form (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, 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 and expenses, including attorneys’ 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/Children’s participation in the Activity is **purely voluntary and is a privilege and not a right**, and that my Child/Children, and I on behalf of my Child/Children, agree to my Child’s/children’s participation in the Activity in spite of the risks.

3. **I agree to instruct my child/children 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 to seek medical treatment of my child/children in the event of any injury, illness or medical emergency occurs during the activity or related travel. 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/children.

5. **I [ ] agree [ ] do not agree that the Archbishop or his agents may use my child’s/children’s portrait or photograph for promotional purposes, website and office functions and use social media and technology to communicate to my child/children regarding ministry related activities.**

6. 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 Authorization to Seek Medical Treatment** shall be effective and binding upon me, my Child/Children, and my own and my Child’s/Children’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 / /

Signature of Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Witness Name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Address City Zip

Place of Employment

Work Address City Zip

Parent or Guardian Phone No. (cell): ; (other Phone No.):

Emergency Contact Phone No. (cell): ; (other Phone No.):

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**Medical Information — Completed by Parent or Guardian — Please Print**

Child’s Name Birth date / /

Allergies

Medications

Chronic Conditions (e.g. epilepsy, diabetes)

Medical Insurance Co. Policy No.

Member’s Name Phone No. (h) (w)

Member’s Birth date / /

Family Doctor Phone No.

Child’s Name Birth date / /

Allergies

Medications

Chronic Conditions (e.g. epilepsy, diabetes)

Medical Insurance Co. Policy No.

Member’s Name Phone No. (h) (w)

Member’s Birth date / /

Family Doctor Phone No.

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**ACTIVITY INFORMATION**

**On-Going Program**

**Church Agency:** St. Paul Catholic Church **Program**: Parish School of Religion (PSR)

**Starting Date: September 1, 2019**  **Ending Date: August 31, 2020**

**Registration Fee: Tuition donations of $25.00 per student/$60.00 per family cap to help defray the costs of books and supplies are greatly appreciated but not required. Please make checks payable to St. Paul Church with the notation “for PSR tuition”.**

**Location:** St. Paul Catholic Church, 308 Phillips St., Yellow Springs Ohio 45387, Parish Office Building (POB), Undercroft & Sanctuary of church building and Mills Lawn Elementary School Park

**Usual day and time: All Grades, Sundays, 9:45 – 11:00am; Confirmation, Sundays, 12:30 -2:00pm;**

**post-Confirmation HS students meet Wednesdays, 4:00 – 5:30pm**

**Routine Activities:** catechesis, prayer, singing

**Group Leader:** Sherry Malloy, Coordinator of Religious Education(CRE)

**Telephone No.: (937) 767-7450, extension 12 Email:** [**cre@stpaulyellowsprings.org**](mailto:cre@stpaulyellowsprings.org)

**Detach and retain for home use**

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