

ARCHDIOCESE OF CINCINNATI PARISH GRADE 8 – HIGH SCHOOL OVERNIGHT RETREAT SPONSORED BY STC AHG TROOP OH 0222 ONE TIME PERMISSION, RELEASE AND AUTHORIZATION TO SEEK MEDICAL TREATMENT (rev. 09-2017)

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* 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 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, agree to my Child’s participation in the Activity 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 to seek medical treatment of my child 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.
5. I agree do not agree that the Archbishop or his agents may use my child’s portrait or photograph for promotional purposes, website and office functions and use social media and technology to communicate to my child 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.
7. I understand that my child’s medical release form is on file at St. Columbkille Faith Formation Office

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, 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 __/__/_____

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.): _____

**Medical Information Needed For Friends Only —
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. _____

(See *Activity Information* form below)

One-Time Activity

Church Agency: St. Columbkille Catholic Church
Activity: Parish Grade 8 – High School Overnight Retreat sponsored by St. Columbkille Troop OH0222
Location: StC Parish Center , 73 N Mulberry St, Wilmington, OH 45177
Emergency Contact Name & Phone No: Denise Reed, 937-218-0660
Cost: Free
Starting Date and Time: Friday, February 15, 2019, 5:00 PM
Meeting Place: St. Columbkille Parish Center
Ending Date and Time: Saturday, February 16, 2019, 12:00 PM
Meeting Place: St. Columbkille Parish Center
Rain Date: None
Activities Involved: Group Activities, Games, Prayer, Crafts and Fellowship.
Type of Transportation (if any): Parent must drop off and pick up from StC Parish Center.
Group Leader Name and Phone Number: Denise Reed, 937-218-0660
Best Phone Number to Reach You At: _____

Other Information

_____ 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 parents(s) or guardian(s))

Page 2 of 2 Signature of Parent/Guardian _____

Date _____