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Permission, Release, Medical Power of Attorney, & Photo Release Form

Group Name: ______________________________

Dates of Activity: ______________________________

1. **I, the undersigned,** will participant in the activity **OR I, the lawful parent or guardian of** ______________________________ **(the "child"),** give permission for my child to participate in the activity. **In both cases**, I release from all liability and indemnify Franciscan Ministries, the Franciscan Sisters of the Poor, and their officers, agents, representatives, volunteers and employees, the Archbishop of Cincinnati ("the Archbishop"), both individually and as trustee for the Archdiocese of Cincinnati, and all parishes and schools within the Archdiocese (the "Archdiocese"), and their 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 Franciscan Ministries, the Franciscans Sisters of the Poor, the Archbishop, the Archdiocese, and their officers, agents, representatives, volunteers and employees.

2. I further understand that my/my Child's participation is purely voluntary and is a privilege and not a right, and that I/my Child, and I on behalf of my Child, elect to participate in spite of the risks.

3. I agree to cooperate/to instruct my child to cooperate with Franciscan Ministries or its agents in charge of the activity.

4. I appoint Franciscan Ministries or its 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 my best interest/the best interest of the Child.

   (ii) I understand that the agents of Franciscan Ministries 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 Franciscan Ministries or its agents may use my/my child's portrait or photograph for promotional purposes, website and office functions and use social media/technology to communicate to me/my child regarding ministry related activities.

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.

for youth:

____
Print YOUTH participant's Name

____
Print Parent/Legal Guardian's Name

______________________________ / /
Parent or Legal Guardian's Signature **date**

for adults:

____
Print ADULT Participant's Name

______________________________ / /
ADULT Participant's Signature **date**

Please see page 2 for Emergency Contact Information and Medical Information

Emergency Medical Form

Personal Information

PLEASE PRINT NEATLY!

/ /

Last Name | First Name | Date of Birth

Street | City | State | ZIP

( ) | ( ) | ( )

Home Phone | Participant's Cell phone | Parent's Cell phone

@ "Class of "

Participant's email address | expected graduation year

@ Male Female

Parent's email address | please circle Participant's Gender

Ethnicity (Optional)

Religious Preference (Optional)

Emergency Contact Information

( )

Legal Guardian, Parent's or Next of Kin's Emergency Phone Number | Name | Relationship to Participant

( )

Other emergency contact's phone number | Name | Relationship to Participant

Medical Information

( )

Physician's Name | Physician's Phone Number

Chronic or Recurring Illnesses:

Medication(s) & Dosage(s):

Allergies to food, drugs or environment:

Other information beneficial in case of emergency:

Health Insurance:

Please copy of both sides of the participant's insurance card below or attach copy to this form.
This ensures quicker processing in case of a medical emergency.