ACTIVITY INFORMATION

St. John the Baptist Catholic Church Youth Ministry; 753 S. Hyatt St. Tipp City, OH 45371

ACTIVITY: Servin the Son ***CAMPERS*** **COST:** $75 (St. John's members); $125 (non-members)

LOCATION: St. John's, Worksites, social sites **EMERGENCY PHONE:** 937-477-8524

START DATE/TIME: August 6-10; 9:00 am **MEETING PLACE:** St. John's Catholic Church

END DATE/TIME: August 6-10; 3pm or 4pm **MEETING PLACE:** St. John's Catholic Church

TRANSPORTATION: Vans **CONTACT:** Teri Iverson **TEL:** 667-3419

TYPE OF ACTIVITIES:

Email: teriiverson@woh.rr.com

ARCHDIOCESE OF CINCINNATI --- PERMISSION, RELEASE AND MEDICAL POWER OF ATTORNEY (Rev. 1/97)

CAMPERS--Servin the Son 2018

1. I, the lawful parent or guardian of _____(the "child"), give permission for my child to participate in the activity described above 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 the 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.
2. I agree to instruct my child to cooperate with the Archbishop or his agents in charge of the activity.
3. (a) 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 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 my 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.

   (b) This power of attorney shall lapse automatically upon completion of the activity and related
4. I agree that the Archbishop of his agent may use by child's portrait or photograph for promotional purposes and office functions.

I have carefully read this statement, and my signature acknowledges that I fully understand the content and meaning.

_____ _____/_____/_____ _____

Signature of Parent or Guardian **(Date)** **(Phone)**

Address_____ City_____ Zip_____ Work Phone_____

Emergency Contact_____ Phone_____

MEDICAL INFORMATION -- Completed By Parent or Guardian -- Please Print

Child's Name_____ Birthdate_____

Allergies_____

Medications_____

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

Medical Insurance Co._____ Policy Number_____

Member's Name_____ Home Phone _____ Work Phone _____

Family Doctor _____ Phone _____

_____ **I Can Drive if Needed**

_____ **# of passengers w/seatbelts**

OFFICE USE: Amt. Paid $_____ Ck#_____

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