St. John the Evangelist Church
Office of Youth & Young Adult Ministry
18 & Older Youth Medical Emergency, Release, and Medical Power of Attorney Form 2018 - 2019

Name_____ Email_____

Home Phone _____ Cell_____ Age _____ Birthdate ____/____/_____

Street Address _____ City _____ State _____ Zip _____

This Medical Emergency, Release, and Medical Power of Attorney Form will cover all onsite activities of St. John the Evangelist Youth Ministry, and including transportation, from the date signed through Aug. 18, 2019. A separate registration form for each offsite activity may also be required.

Please notify us if any information given below changes throughout the year. Thank you.

ARCHDIOCESE OF CINCINNATI
RELEASE AND INDEMNIFICATION AND MEDICAL POWER OF ATTORNEY

1. I, the undersigned will participate in the activity described on the *Activity Information* form 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 and schools within the Archdiocese (the "Archdiocese"), agents, representatives, volunteers, and employees of the Archdiocese, from any and all liability, claims, judgments, cost and expenses, including attorneys' fees, arising out of any injury or illness incurred by me 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, any claims, lawsuits or actions against the Archbishop, and the officers, agents, representatives, volunteers and employees of the Archdiocese,.
2. I further understand that my participation is purely voluntary and is a privilege and not a right. I elect to participate in spite of the risks.
3. I agree 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 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.

5. I agree that the Archbishop or his agents may use my/my child's portrait or photograph for promotional purposes, website and office functions and use social media and technology to communicate to me/my child regarding ministry related activities. (Facebook, texting, etc.)
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 Medical Power of Attorney shall be effective and binding upon me and my own personal representative or estate, assigns, heirs, and next of kin and that I have signed this agreement of my own free will. (If the person 18 or older is in high school, both signatures are required below.)

_____	_____	_____/_____/_____
Signature (of person age 18 & above)	Print Name	Date
_____	_____	_____/_____/_____
Parental Signature	Print Parent Name	Date

School if Above is in High School & Age 18_____ Grade _____

Insurer's Name _____ Relationship to Above _____ Insurer's Employment _____

Insurer's Work Phone _____ Insurer's Cell _____ Insurer's Email _____

Medical Insurance Company_____ Policy Number _____

Medications _____
Allergies/Disorders/
Chronic conditions (e.g. epilepsy, diabetes) _____

Primary Doctor _____ Phone _____ Other Doctor #_____

Emergency Contact _____ **Relationship** _____ **Phone** _____

Please return form to St. John Church Youth & Young Adult Ministry, 9080 Cincinnati-Dayton Rd, West Chester, OH 45069