

Activity Information
Immaculate Heart of Mary School, Cincinnati, Ohio

Today's Date _____

Dear Parent or Guardian:

A school-sponsored activity that requires transportation to a location away from the school site has been planned for your child's class. This activity will take place under the supervision of employees of Immaculate Heart of Mary School. Field trips are privileges afforded to students. No student has an absolute right to a field trip. Students can be denied participation if they fail to meet academic or behavioral requirements.

The following is a brief description of the activity: _____

Curriculum Goal: _____

Destination: _____

Designated Supervisor(s): _____

Date and Time of Departure: _____

Date and Anticipated Time of Return: _____

Method of Transportation: _____

Cost including transportation and any entrance fees _____
(Make checks payable to Immaculate Heart of Mary School)

If you would like your child to participate in this activity, please complete and sign the following statement of consent and release of liability and return it to school no later than _____.

*** *Parents, please read and sign the Archdiocese of Cincinnati Permission, Release, and Medical Power of Attorney form attached to this form * ***

I hereby request that my child, _____, be permitted to participate in the activity described above. I understand that this activity will take place away from the school grounds, that the school will arrange transportation, and that my child will be under the supervision of the designated person on the date specified. I release and agree to indemnify Immaculate Heart of Mary School and its representatives from liability for any accident in which my child may be involved or any injury to my child that may occur in connection with this activity. I consent to the conditions for participation in this activity, including the method of transportation.

I recognize that I remain fully responsible for any legal liability resulting from personal action by my child.

Witness my signature this _____ day of _____, 20__

Parent/Guardian Signature

STUDENT PARTICIPANT

I understand that I am subject to the rules of conduct specified by the school, and I agree to abide by them as well as the directions of the designated supervisors of this activity.

Student Participant Signature

ARCHDIOCESE OF CINCINNATI PERMISSION, RELEASE AND MEDICAL POWER OF ATTORNEY

1. I, the lawful parent or guardian of (the "Child"), give permission for my Child _____ to 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"), and their officers, agents, representatives, volunteers, and employees from any and all liability, claims, judgments, costs 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 officers, agents, representatives, volunteers and employees.

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

- 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 the Child.
- 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. This power of attorney shall lapse automatically upon completion of the activity and any related travel.

6. I agree that the Archbishop or his agents may use my Child's portrait or photograph for promotional purposes, website and office functions.

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.

Signature of Parent or Guardian _____ Date _____
 Home Address _____ City _____ Zip _____
 Place of Employment _____
 Work Address _____ City _____ Zip _____
 Parent or Guardian Phone No. (w) _____ (h) _____
 Emergency Contact Phone No. (w) _____ (h) _____

Medical Information — Completed by Parent or Guardian — Please Print

Child's Name _____
 Birth date _____
 Child's Soc. Sec. No. * _____
 Allergies _____
 Medications _____
 Chronic Conditions (e.g. epilepsy, diabetes) _____
 Medical Insurance Co. Policy No. _____
 Member's Name Phone No. (h) _____ (w) _____
 Member's Birth date _____ Member's Soc. Sec. No. * _____
 Family Doctor _____ Phone No. _____

* Social Security Number is optional. Please note that some hospitals WILL NOT treat without it. (See Activity Information form)