2011-2012 CATHOLIC RELIGIOUS EDUCATION REGISTRATION

St. Leonard Faith Community, 8100 Clyo Road, Centerville, OH 45458

Paid $_________

Check#________

Date: ___/___/___

Family Name____

Street Address____

City ____ Zip Code ______________________

Home Phone (_____)___________________ Unlisted? Y N Family email:___________________________________

Father:____ Mother:____

Religion:____ Religion:____

Occupation:____ Occupation:____

Cell Phone ____ Cell Phone____

E-mail ____ Email:____

Children live with: _____ both parents _____ mother _____ father _____ other: ___________________________

<u>Please include copies of certificates for Baptism and Confirmation if you have not previously done so</u>.

<u>STUDENT INFORMATION</u>

Student Name ____ Date of Birth____/____/____ Gender: M F

Grade for 2011-2012__________ School Attending:____

*SSN: (Optional)____ *For medical treatment purposes only.

Allergies, Medical Conditions, Learning or Personal Issues:________ ____

____

Sacraments Received:

Baptism date:___________________ Church:____ _______________________

First Communion ___________ Reconciliation ____________ Confirmation ___________

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PARENTAL PERMISSION, RELEASE OF LIABILITY AND MEDICAL POWER OF ATTORNEY

1. As a parent or legal guardian of the participants, I give my permission for my child/children to register for, and to participate in, religion classes and associated activities of St. Leonard Faith Community during the 2011–2012 school year ("the Activity").

2. I release from all liability, and indemnify and hold harmless 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 of either the Archdiocese or any parish thereof ("Agents") from any and all liability, actions, causes of action, claims, judgments, costs or expenses, including attorney fees, known or unknown at this time, arising out of or in any way related to any injury or illness incurred by my child/children while participating in or traveling to or from the Activity.

3. I agree to instruct my child/children 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 in my name and on 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; to give any and all consents and authorizations to any physician, 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/children.

5. 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/children.

6. This Power of Attorney shall lapse automatically upon completion of the Activity.

I have read and understand all contained in this Agreement:

____

Signature of Parent/Guardian   Date

EMERGENCY CONTACT INFORMATION

Emergency Contact Person:____

Phone:____ Relation to Child(ren):___________________________________

MEDICAL INFORMATION – PLEASE PRINT

Medical Insurance Co.:____

Policy No.:____ Name of Insured:_______________________________________

Family Physician:____ Phone:________________________________

Family Dentist:____ Phone:________________________________

Preferred Hospital:____

PART I: CONSENT TO TREATMENT

In the event reasonable attempts to contact me at the phone numbers provided have been unsuccessful, I hereby give my consent for:

- ☐ The administration of any treatment deemed necessary by my preferred physicians (listed above) or, in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and
- ☐ The transfer of the child to the preferred hospital list above, or any hospital reasonably accessible.

This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity for such surgery, are obtained before surgery is performed.

Parent/Guardian Signature:____ Date:_____/_____/_____

PART II: REFUSAL TO CONSENT TO TREATMENT (do not sign if completed Part I)

I DO NOT give my consent for emergency medical treatment of my child. In the event of illness or injury requiring emergency treatment, I wish the Community authorities to take no action.

Parent/Guardian Signature:____ Date:_____/_____/_____