<u>Moeller Band 7th and 8th Grade Day</u>

Student's Name: ___________________________

Parent's Name: ____

Parish/School: ____________________________

Grade: _______

Instrument: ____________________________

Phone Number: ________________ **e-mail:** ________________________

Shirt Size: _________

Please mail to:
Moeller High School
9001 Montgomery Rd.
Cincinnati, OH 45242

or email the above information to:
bbrowning@moeller.org

Parents will also need to fill out the Archdiocesan Medical Release form below

This must be signed and turned in before boarding bus.

Activity: Moeller Football Game Date: October 20, 2007
Location (Place, city): University of Cincinnati Emergency Phone: ____________________
Starting Time: 4:30 PM Meeting Place: Moeller HS
Ending Time: 11:00 PM Meeting Place: Moeller HS
Type of Transportation: bus
Contact Person: Bob Browning Phone: 513-792-3350 (band room)
Other Information: ____________________

ARCHDIOCESE OF CINCINNATI
RELEASE AND INDEMIFICATION AGREEMENT AND MEDICAL POWER OF ATTORNEY

1. I, the lawful parent or guardian of ____(“the child”) release from all liability, and indemnity and hold harmless the Archbishop of Cincinnati (“the Archbishop”), both individually and as a trustee for the Archdiocese of Cincinnati and all parishes within the Archdiocese, and officers, agents, representatives, volunteers, and employees of either the Archdiocese or any parish or school thereof (“agents”) from any and all liability, actions, causes of action, claims, judgments, cost 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 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. In the event reasonable attempts to contact me have been unsuccessful, I hereby give my consent for (1) the administration of any treatment deemed necessary by _________________________________ (doctor), or, __________________________________, dentist, or in the event the designated preferred practitioner is not available, by another licensed physician or dentist; and (2) the transfer of the child to any hospital reasonably accessible. Preferred local hospital: ____This authorization does not cover major surgery unless the medical opinions of two other licensed physicians or dentists, concurring in the necessity of such surgery, are obtained prior to the performance of such surgery.

4. I also agree to the following:
The posers of authority granted herein may be revoked by me by written notice delivered to the Archbishop or his agents who are then acting or who has previously acted hereunder. Without such written notice, this power of attorney shall not he affected by my disability, incapacity or adjudicated incompetence. This power of attorney shall lapse automatically upon completion of the activity and the return of my child to the Ending Place.
5. I agree that the Archbishop or his agents may use my child’s portrait or photograph for editorial purposes and office functions (excluding Internet postings), and hereby release the Archbishop and his agents from any liability resulting from such use.

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

Signature of Parent or Guardian Date Phone #s during event
home:

Cell:

X ____