

Totus Tuus *Totally Yours*

Registration and Release Form

Summer 2018

Totus Tuus Program

Totus Tuus for grades 1-6 meets on Monday-Friday from 9:00am-2:30pm for classes, games, skits, lunch, and recess.
 Totus Tuus for grades 7-12 meets on Sunday-Thursday from 7:00-9:00pm for classes, games, snacks, and activities in the Church.

Church Agency _____ Usual Location _____
 Starting Date _____ Ending Date _____ Registration Fee _____
 Group Leader _____ Telephone No. _____

<u>Name of Student(s)</u>	<u>Date of Birth</u>	<u>Grade Entering</u>	<u>School</u>

Registration Fee is \$20/student with a maximum of \$50/family

Medical/Liability Information — Completed by Parent or Guardian — Please Print

Mother's Name _____ Father's Name _____
 Mother's Maiden Name _____ Child's Soc. Sec. No. * _____
 Home Address _____ City _____ Zip _____
 Chronic Conditions (e.g. epilepsy, diabetes) _____
 Allergies/Medications _____
 Other information we should know about your child _____
 Parent/Guardian Place of Employment _____
 Parent or Guardian Contact No. (c) _____ (h) _____ (w) _____
 E-mail Address (Notification sent for cancellation) _____
 Emergency Contact _____ Phone No. (c) _____ (h) _____
 Medical Insurance Co. _____ Policy No. _____
 Member's Name _____ Phone No. (h) _____ (c) _____
 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.

ARCHDIOCESE OF CINCINNATI
PERMISSION, RELEASE AND
AUTHORIZATION TO SEEK MEDICAL TREATMENT (rev. 09-2017)

1. I, the parent or lawful guardian of _____ (the “child”), give permission for my child to participate in the activity described on the *Activity Information* form (the “Activity”) and release from all liability and indemnify the Archdiocese of Cincinnati (the “Archdiocese”), the Archbishop of Cincinnati (the “Archbishop”), both individually and as trustee for the Archdiocese, and all parishes and schools within the Archdiocese, and their respective officers, agents, representatives, volunteers, and employees from any and all liability, claims, judgments, cost 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 respective officers, agents, representatives, volunteers and employees.

2. I further understand that my Child’s participation in the Activity is purely voluntary and is a privilege and not a right, and that my Child, and I on behalf of my Child, agree to my Child’s participation in the Activity 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 to seek medical treatment of my child in the event of any injury, illness or medical emergency occurs during the activity or related travel. 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. I agree do not agree that the Archbishop or his agents may use my child’s portrait or photograph or video for promotional purposes, website and office functions and use social media and technology to communicate to my child regarding ministry related activities.

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 Authorization to Seek Medical Treatment 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 ___/___/_____

Signature of Witness: _____ Witness Name (please print): _____

Home Address _____ City _____ Zip _____

Place of Employment _____

Work Address _____ City _____ Zip _____

Parent or Guardian Phone No. (cell): _____; (other Phone No.): _____

Emergency Contact Phone No. (cell): _____; (other Phone No.): _____

