DIVINE MERCY HOMESCHOOL COOPERATIVE
PERMISSION, RELEASE AND MEDICAL POWER OF ATTORNEY (rev. 04-2018)

1. I, the undersigned and the parent or lawful guardian of **(name all children who may be on site for any reason)**

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

(the "Child(ren)"), will participate and give permission for my Child(ren) to participate in the educational classes and administrative duties of the cooperative (the "Activity"), and I hereby release from all liability and indemnify the Divine Mercy Homeschool Cooperative (the "Co-op"), the Instructors of each class (the "Instructors"), both individually and as teachers for the Co-op, 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 me and my Child(ren) 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(ren), any claims, lawsuits or actions against the Instructors, the Co-op, and their respective officers, agents, representatives, volunteers and employees.

2. I further understand that my and my Child(ren)'s participation in the Activity is purely voluntary and is a privilege and not a right. I elect to participate in the Activity in spite of the risks. My Child(ren), and I on behalf of my Child(ren), agree to my Child(ren)'s participation in the Activity in spite of the risks.

3. I agree to cooperate with the Instructors or their agents in charge of the Activity. I agree to instruct my Child(ren) to cooperate with the Instructors or their agents in charge of the Activity.

4. I appoint the Instructors or their 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 and for the best interest of the Child(ren).

(ii) I understand that the agents of the Instructors will make a reasonable attempt to contact me as soon as possible in the event of a medical emergency involving my Child(ren).

5. This power of attorney shall lapse automatically upon completion of the Activity and related travel.

6. I agree that the Instructors or their agents may use a photograph, video or other likeness of me and my Child(ren) for promotional purposes, website and office functions and use social media and technology to communicate to me and my Child(ren) regarding educational related activities.

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(ren), and my own and my Child(ren)'s personal representative or estate, assigns, heirs, and next of kin and that I have signed this agreement of my own free will.

Father's Signature _____ Date _____/_____/_____

Mother's Signature _____ Date _____/_____/_____

Family Information — Please Print

Family Name _____ Home Phone No. _____

Father's Name _____ Phone No. (c) _____ (w) _____

Mother's Name _____ Phone No. (c) _____ (w) _____

Mother's Email _____ Father's Email _____

Home Address _____ City _____ Zip _____

Emergency Contact 1 _____ Relationship _____

Phone No. (h) _____ (c) _____ (w) _____

Emergency Contact 2 _____ Relationship _____

Phone No. (h) _____ (c) _____ (w) _____

Child's Information — Completed by Parent or Guardian — Please Print

Name _____ Birthdate _____/_____/_____

Phone No. (c) _____ Soc. Sec. # * _____

Allergies _____

Medications _____

Chronic Conditions (e.g. epilepsy, diabetes) _____

Medical Insurance Co. _____ Policy No. _____

Member's Name _____ Phone (h) _____ (w) _____

Member's Birth date _____/ _____/_____ Member's Soc. Sec. # * _____

Doctor _____ Phone _____

* Social Security number is optional. Please note that some hospitals WILL NOT treat without it.

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