Family Last Name (Please Print) _____

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 _____/_____/_____

ASSUMPTION OF RISK AND WAIVER OF LIABILITY
Divine Mercy Homeschool

I acknowledge [for myself and/or my child(ren)] the highly contagious nature of infectious diseases, including, but not limited to, COVID-19 and its variants, as well as their potential to cause infection, illness, injury, permanent disability, and death. I voluntarily accept and assume the risk that I may be exposed to or infected by an infectious disease by visiting/participating/attending Divine Mercy Co-op operated by Divine Mercy Homeschool. I further accept [for myself and/or my child(ren)] and assume the risk that such exposure or infection may result in my [my child(ren)] personal injury, illness, permanent disability, and/or death. Divine Mercy Homeschool cannot prevent you [for yourself and/or your child(ren)] from becoming exposed to, contracting, or spreading an infectious disease while visiting/participating/attending Divine Mercy Co-op. It is not possible to prevent the presence of these diseases. Therefore, if you [for yourself and/or your child(ren)] choose to visit/participate/attend Divine Mercy Co-op you [for yourself and/or your child(ren)] may be exposing yourself [your child(ren)] to and/or increasing your risk of contracting or spreading an infectious disease.

I understand that the risk of becoming exposed to or infected by an infectious disease may be increased as a result of the actions, omissions, and/or negligence of Divine Mercy Homeschool, including its independent contractors, agents, vendors, guests, and employees. I voluntarily assume [for myself and or my child(ren)] all of the risks of an infectious disease and of an infectious disease exposure and accept sole responsibility for any harm to me [my child(ren)] (including, but not limited to, personal injury, illness, permanent disability, and death).

In consideration of Divine Mercy Homeschool allowing me onto its premises/visiting/participating/attending Divine Mercy Co-op, I also, on behalf of myself [my child(ren)] and my successors and representatives, waive, release, and forever discharge Divine Mercy Homeschool, its agents, employees, officers, directors, contractors, customers, successors, and assigns from any and all claims and causes of action of any kind or nature which are in any way related, directly or indirectly, to an infectious disease, which I may have or that hereafter may accrue, including any such claims or causes of action caused in whole or in part by the negligence of Divine Mercy Homeschool, its agents, employees, officers, directors, contractors, customers, successors, and assigns. I [for myself and/or my child(ren)] further agree that I will not bring any claim or cause of action against Divine Mercy Homeschool, its agents, employees, officers, directors, contractors, customers, successors, and assigns related in any way, directly or indirectly, to an infectious disease, and/or any associated personal injuries, illness, disability, or death.

I [for myself and/or my child(ren)] further agree to indemnify, defend, and hold harmless Divine Mercy Homeschool, its agents, employees, officers, directors, contractors, customers, successors, and assigns from any claims or causes of action of any kind arising from my exposure to an infectious disease as a result of visiting/participating/attending Divine Mercy Co-op provided by Divine Mercy Homeschool.

Children

_____ _____

_____ _____

_____ _____

_____ _____

Parent's Name - PRINT

_____

Parent'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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