Ascension Vacation Bible School 2015

July 13-17

8:45am—11:30am

Witzman Center

Cost: $15.00 per camper (max $45.00 per family)

Ages: Preschool (4 years old) through Grade 5

Registration is on a first come-first serve basis;
BOTH sides of this form and full payment must be received in the RE Office
no later than Monday, July 6.
For information contact VBS Coordinator Lauren Boyd at lboyd@ascensionkettering.org or Corrina Campos at ccampos@ascensionkettering.org

Or the RE Office at 254-0622, reoffice@ascensionkettering.org

CAMPER REGISTRATION

Child's Name	Age	Grade (Sep.'15)

Parent's Name: _____

Email Address: _____

Phone: _____ _____ _____
Home **work** **cell**

Emergency Contact: _____/_____
Name **Phone**

Office Use Only

Date pd: _____ Amount: _____ Check/cash_____ No: _____ CD _____
(initials)

Archdiocese of Cincinnati
Permission, Release and Medical Power of Attorney

1. I, the lawful parent or guardian of (please list children's names)_____

   _____

   give permission for my child to participate in Vacation Bible School described above, and release from all liability and indemnify the Archbishop of Cincinnati ("The Archbishop"), both individually and as trustee for the Archdiocese of Cincinnati and all parishes within the Archdiocese, and their officers, agents, representatives, volunteers, and employees from any and all liability, claims, judgments, costs or expenses, including attorney fees, arising out of 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. I appoint the Archbishop or his 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:
   A. 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 dentist treatments, diagnostic or surgical procedures or any other emergency actions as our attorney shall deem necessary or appropriate for the best interest of the child.
   B. 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.
   C. This power of attorney shall lapse automatically upon completion of the activity and related travel.
4. I agree that the Archbishop or his agents may use my child's portrait or photograph for promotional purposes, website and office functions.

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

Signature of Parent or Guardian _____ DATE ___/____/____

Work Phone: _____ Cell Phone: _____

Medical Insurance Company _____Policy No._____

Members Name _____

Family Doctor Name _____Phone_____

Dentist Name _____ Phone_____

Medical Information to be completed by Parent or Guardian (Please Print clearly)

Child's Name _____
Birth Date _____Grade _____
Allergies _____
_____
Medications_____
Chronic Conditions (e.g. epilepsy, diabetes) _____
_____

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