Bishop Leibold

Creative Cooking Club

Student Name _____

2018-19 Grade Level 4 5 6 7 **Gender** M F

Parent Name_____ **Email**_____

Please choose session(s):

	Fourth Grade- Tuesday, October 9 | 3:00 -5:15 p.m. Come and enjoy this session planned especially for our fourth graders. Eighth graders will lead 4 stations where participants will create, cook, and eat the recipes they learn. Come enjoy Crazy Cakes and more...
	Fifth Grade- Tuesday, January 15 | 3:00-5:15 p.m. More information coming soon!
	Sixth Grade- Tuesday, March 12 | 3:00-5:15 p.m. More information coming soon!
	Seventh Grade- Tuesday, May 7 | 3:00- 5:15 p.m. More information coming soon!

We reserve the right to make changes to the schedule if there are schedule conflicts/ inclement weather. We will notify registered participants in advance via e-mail.

Payment Type ($10/session) Check _____

Cash _____

Total Payment amount_____

(If multiple siblings attending, please write one check)

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 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.):_____

Medical Information — Completed by Parent or Guardian — Please Print

Child's Name _____ Birth date__/__/__

Allergies _____

Medications_____

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

Medical Insurance Co._____ Policy No. _____

Member's Name _____ Member's Birth date__/__/__

Phone No. (h) _____ (w) _____

Family Doctor _____ Phone No. _____

(See Activity Information below)

On-Going Program

Church Agency Bishop Leibold School Program or Group Creative Cooking Club

Starting Date 10/1/18 Ending Date 4/30/19 Registration Fee $10/session

Usual Location St. Henry Parish Meeting Room 6696 Springboro Pike Dayton, OH 45449

Usual day and time Tuesday from 3:00-5:15

Routine Activities Cooking and baking club

Group Leader Mrs. Beth Allaire Telephone No. 9374349343

Other Information (attached)

__X___ Check here if any additional information is attached. (Note: any additional activity information (e.g. schedule, list of specific activities, etc.) may be attached to further inform parents(s) or guardian(s).

Signature of Parent/Guardian _____ Date __/__/__