



**SETON HIGH SCHOOL
ATHLETIC DEPARTMENT**

3901 Glenway Avenue • Cincinnati, Ohio 45205-9986 • (513) 471-2600 ext. 2416 • www.setoncincinnati.org

2026-2027

ATHLETE'S NAME _____ **SPORT/LEVEL** _____ **GRADE** _____

**ARCHDIOCESE OF CINCINNATI / SETON HIGH SCHOOL
RELEASE AND INDEMNIFICATION AGREEMENT AND MEDICAL POWER OF ATTORNEY**

1. I, the lawful parent or guardian of _____ (the "child"), give permission for my child to participate in athletics and release from all liability and indemnify and hold harmless the Archbishop of Cincinnati ("the Archbishop"), both individually and as trustee for the Archdiocese of Cincinnati and all parishes and schools within the Archdiocese, and their officers, agents, representatives, volunteers, and employees from any and all liability, claims, judgments, cost or expenses, including attorney fees, arising out of an injury or illness incurred by my child while participating in or traveling to or from any athletic 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 in any injury, illness or medical emergency that occurs during the activity:
 - a. To give any and all consents and authorizations to any physician, dentist, hospital or other persons or institutions pertaining to any emergency medication, medical or dental 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.
4. This power of attorney shall lapse automatically upon completion of the athletic season and related travel.

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

Signature of Parent or Guardian _____ Date _____

Address _____

Home Phone _____ Work Phone _____ Cell Phone _____

Emergency Contact _____ Relationship _____ Phone _____

MEDICAL INFORMATION

Please Print

Athlete's Name _____ Birthday _____

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

Medications _____

Medical Insurance Co. _____ ID # _____ Group No. _____

Subscriber Name _____ Subscriber Birthdate _____

Subscriber Home Phone _____ Subscriber Work Phone _____

Family Doctor _____ Phone _____

Family Dentist _____ Phone _____