

# Totus Tuus \*Totally Yours\*

## Registration and Release Form

### Totus Tuus Program

Totus Tuus for grades 1-6 meets on Monday-Friday from 9:00am-2:30pm for classes, games, skits, lunch, and recess.  
 Totus Tuus for grades 7-12 meets on Sunday-Thursday from 7:00-9:00pm for classes, games, snacks, and activities in the Church.

**Church Agency:** Basilica of St. Mary of the Assumption **Meeting Locations:** Day Program- St. Mary School  
 Evening Program- Basilica

**Starting Date:** June 13 **Ending Date:** June 17 **Registration Fee:** \$20 per family

**Group Leader:** Cecelia Cottrill **Telephone No.:** 740-373-3643

<u>Name of Student(s)</u>	<u>Date of Birth</u>	<u>Grade Entering</u>	<u>School</u>

### Registration Fee is \$20 per family

#### Medical/Liability Information — Completed by Parent or Guardian — Please Print

Mother's Name \_\_\_\_\_ Father's Name \_\_\_\_\_

Mother's Maiden Name \_\_\_\_\_ Child's Soc. Sec. No. \* \_\_\_\_\_

Home Address \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Chronic Conditions (e.g. epilepsy, diabetes) \_\_\_\_\_

Allergies/Medications \_\_\_\_\_

Other information we should know about your child \_\_\_\_\_

Parent/Guardian Place of Employment \_\_\_\_\_

Parent or Guardian Contact No. (c) \_\_\_\_\_ (h) \_\_\_\_\_ (w) \_\_\_\_\_

E-mail Address (Notification sent for cancellation) \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Phone No. (c) \_\_\_\_\_ (h) \_\_\_\_\_

Medical Insurance Co. \_\_\_\_\_ Policy No. \_\_\_\_\_

Member's Name \_\_\_\_\_ Phone No. (h) \_\_\_\_\_ (c) \_\_\_\_\_

Member's Birth date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Member's Soc. Sec. No. \* \_\_\_\_\_

Family Doctor \_\_\_\_\_ Phone No. \_\_\_\_\_

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

**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 or video 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.): \_\_\_\_\_

