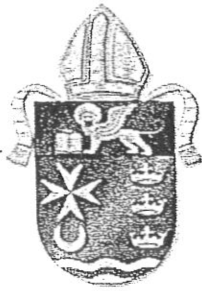

DIOCESE OF VENICE IN FLORIDA

## REQUEST FOR MEDICAL PROCEDURE AT SCHOOL
## AFFIDAVIT, MEDICAL RELEASE OF LIABILITY & INDEMNIFICATION

STUDENT NAME: ______________________________ DOB ____________________

LOCATION: Clinic ____________________ FACULTY: Gina Fair, Nurse

MEDICAL CONDITION REQUIRING CARE: ________________________________________

MEDICAL CARE NEEDED: ________________________________________

*******************************************************************************************

1. I, the undersigned parent/legal guardian of the above student, who is currently enrolled in ____________ ____________________ School, attest that it is or may be necessary for the minor student to have a medical procedure performed during school hours. I understand that this is not a usual service the school provides, and the request may be denied by the school administration.

2. **I attest that I have a copy of a physician's order for this procedure.**

3. I am aware that the school does not employ qualified medical personnel. I request that this procedure be administered by non-medical school personnel who have been instructed in the performance of this procedure by qualified medical personnel. I hereby release, discharge and covenant not to sue the Bishop of the Diocese of Venice, individually and as a corporation sole, the Diocese, the above referenced school, their respective clerics, employees and agents (hereinafter Releasees) from any claim, demand, action or liability whatsoever, in any way related to the administration of the medical procedure referenced herein, and further agree to indemnify and hold them harmless from any loss, liability or damage they may incur incident to the administration of the medical procedure, whether caused in whole or part by the ordinary negligence of Releasees or otherwise.

4. I agree that if any special equipment is needed to perform this procedure, it will be maintained by me; delivered to the school in working order as often as needed, and that school personnel shall have no responsibility for the maintenance or delivery of the following special equipment:

   ________________________________________________________________.

5. I have been advised that the following school personnel have received specific training in this procedure, have demonstrated an understanding of, an ability and willingness to perform the requested procedure:

________________________________ ________________________________

________________________________ ________________________________

and that these personnel have been trained by ______________________________ *(please indicate whether trainer was an RN, LPN, certified physician assistant or a physician licensed under Chapter 458 or 459)*

6. In the absence of trained personnel, and in an emergency situation, I understand 911 will be called.

Parent/Guardian Signatures: ____________________ / ____________________

Address: ______________________________ Phones: ____________________

PHYSICIAN'S PERMISSION FOR MEDICATION

Date: ______________________

Dear Dr. ______________________________________:

According to our records, ______________________________, who attends ____________

Bishop Verot Catholic High School, Inc. , is required to take medication.

F.S. 232.46 provides for administration of medication by school personnel. Whenever possible, medications should be scheduled outside of school hours.

Only medications ordered by a physician or dentist may be administered in school.

Your written permission is needed when:

1. Prescribed medication is to be taken for longer than two weeks.
2. Any over-the-counter medications including aspirin and cough drops or syrups are prescribed.
3. Medications with increasing or decreasing dosages are part of the therapeutic plan. Please be specific regarding dates, parameters, etc. Attach additional sheet if needed.

We appreciate your cooperation with this request.

| Medication | Time of Day to be Taken | Amount/Number to be Taken | Duration of Medication Beginning-Ending Date |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Comments: ______________________________________________________________

______________________________________________________________

Are there any reactions that might occur which you would like to have reported to you? __________

______________________________________________________________

Date: ______________________

______________________________
Physician's Signature

______________________________
Phone Number