Diocese of Venice
1000 Pinebrook Road, Venice, FL 34285
(941) 484-9543

REQUEST FOR MEDICAL PROCEDURE
AFFIDAVIT, MEDICAL RELEASE OF LIABILITY & INDEMNIFICATION

STUDENT NAME: ______________________________ DOB ______________________________

HOME ROOM: ___________________________ TEACHER: ______________________________

MEDICAL CONDITION REQUIRING CARE: ____

MEDICAL CARE NEEDED: ____

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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

2. **I attest that I have attached 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 child-specific training, 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: ______________________________

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STATE OF FLORIDA, COUNTY OF ________________

Sworn to and subscribed before me this _____ day of ____________, ____ who is personally known to me, or who produced the following as identification ____________________________________.

____
Signature of Notary Public

(SEAL)

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Please return this form to the school or parish office.

Typed or printed name.
Commission No.