PARENT/MEDICAL PROVIDER REQUEST FOR CAREGIVER TO ADMINISTER MEDICAL MARIJUANA AT SCHOOL

Student's Name:_____ DOB:_____

Note: Medical marijuana can only be administered at school or on a school bus to <u>a student under the age of 18</u> by the student's designated primary caregiver (who must be a parent, guardian, or legal custodian.)

School: _____Grade:_____

A. To be completed by Physician or Certified Nurse Practitioner:

Reason for use of medical marijuana: _____

_____

Form of medical marijuana: _____

Note: Medical marijuana may only be administered at school in a non smokeable form. Electronic Delivery Systems (vaping devices) are not permitted as a means of consuming medical marijuana in school.

Dosage (amount):_____

The medical marijuana <u>must</u> be administered during school hours: □ Yes □ No

If yes, time to be administered:_____

Note: Medical Marijuana may not be held, possessed, or administered by anyone other than the primary caregiver.

_____

Restrictions, including any restrictions on school activities for safety reasons (i.e. driving, operating equipment, participating in contact sports, etc.) and/or potential side effects:

□ None anticipated

□ Yes. Please describe in detail:_____

_____

Date of certification for medical marijuana use:_____

Date to be discontinued:_____

Any other necessary instructions or information: _____

_____

NOTE: THE SCHOOL NURSE MAY CONTACT YOU IF THERE ARE FURTHER QUESTIONS CONCERNING THIS REQUEST.

Provider's Signature:_____Date:_____

Printed Name:_____

Address:_____

Phone Number:_____ Fax Number:_____

Email Address: _____

Note: Any changes to the information above shall require a new request/permission form.

B. To be completed by parent/guardian/legal custodian (designated "primary caregiver" under Maine law for medical use of marijuana purposes):

I understand and agree that if the school nurse has questions regarding the provider's recommendation, that the nurse may contact the child's provider and obtain additional information about the medication. I consent to the provider releasing that information.

I have read Board Policy JLCD – Administering Medication to Students and understand that I must comply with all the requirements concerning the administration of medical marijuana.

Signature:_____ Relationship:_____

Date:_____

NOTE: A COPY OF THE CURRENT WRITTEN CERTIFICATION FOR THE USE OF MEDICAL MARIJUANA MUST BE ATTACHED TO THIS FORM.

C. To be completed by school:

Date received:_____ By whom:_____

Date reviewed:_____ Reviewed by:_____

Adopted: March 1, 2018