

**BVSD Medical Marijuana Administration Plan
(Pursuant to Board Policy JLCDB)**

To be completed by the parent/guardian:

Name of Qualified Student: _____

School: _____ Grade: _____

Name of Student's Parent/Guardian/Primary Caregiver: _____

Phone Number for Student's Parent/Guardian/Primary Caregiver: _____

Person who will administer: _____

Permissible form of medical marijuana to be administered:

Oil Tincture Edible Product Other: _____

Administration method used: _____

Dosage Amount: _____ Time(s) to be Administered: _____

Location of Administration: _____ Secured Storage Location: _____

By initialing the following statements and signing below, the undersigned parent/guardian hereby acknowledges:

____ I have read and agree to comply with the procedure regarding the administration of medical marijuana to qualified students.

____ I assume all responsibility for the provision, administration, maintenance and use of medical marijuana to my child.

____ I grant permission for the designated volunteer school personnel to store, administer, or assist in the administration of medical marijuana to my child.

____ I understand that the district, with my input, will determine a designated location and any protocols regarding the administration of medical marijuana to my child and that this plan does not allow for the administration of medical marijuana on federal property or any location that prohibits marijuana on its property.

____ I understand that permission to administer medical marijuana in accordance with this plan may be revoked for the failure to comply with the procedure on the administration of medical marijuana to qualified students or other policies.

Date: _____

Signature of parent or guardian

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To be completed by the School Administrator:

By initialing the following paragraphs and signing below, the undersigned school administrator acknowledges:

_____ I have verified the qualified student's current State of Colorado medical marijuana registration card has an expiration date of _____ and will maintain a copy of the registration card in the student's records.

_____ I have received input from the qualified student's parent/guardian/primary caregiver on the plan.

_____ I have determined the Qualified Student's Administration Plan complies with Board Policy and may be implemented.

Date: _____ Signature of Administrator: _____

To be completed by the volunteer school personnel, if applicable:

By initialing the following paragraphs and signing below, the undersigned volunteer(s) acknowledges:

_____ I have read and agree to comply with the Board's policy regarding the administration of medical marijuana to qualified students.

_____ I have read and understand the Student's written plan for the administration of medical marijuana.

_____ I voluntarily agree to administer the student's medical marijuana in accordance with the written plan.

Date: _____ Signature of Administrator: _____