

THE SCHOOL BOARD OF BROWARD COUNTY, FLORIDA

Coordinated Student Health Services, 1400 NW 14th Court, Ft. Lauderdale, FL 33311

All Grades

Use of Medical Marijuana for Qualified Students

VOID if Altered

Effective for the school year 20____-20____

Student/Parent Information

Student's Name:	Birth Date:	Allergies:	Grade:
Parent/Guardian (Print Name):		Address:	
Home Phone:	Work Phone:	Other Phone:	

Caregiver Name (Print Name):

Phone Number:

Registration ID Number:

Caregiver Signature:

Date:

Physician Name (Print Name):

Registration ID Number:

Address:

Phone Number:

Fax Number:

Name of Medication

Dosage

Route

Time

Side Effects/Special Instruction

Has the child displayed any signs and symptoms, adverse outcomes after receiving the medical marijuana? If so please describe the signs, symptoms, or adverse reaction.

Physician Signature: _____

Date: _____

Parental Permission (To be completed by Parent/Guardian only)

By signing below, I (the parent or legal guardian) understand that the medical marijuana will not be administered by school staff or healthcare personnel in the school. I assume full responsibility for any consequence resulting from the administration of medical marijuana. I understand and have discussed with my son/daughter that if he/she sells or transmits this medication, he/she will be consequence based upon the District's Discipline Matrix. I am also releasing The School Board of Broward County, Florida, from any liability that results in my son/daughter selling or transmitting any of the medications identified above.

Parent Signature:

Date: