MSAD 52
PARENT/MEDICAL PROVIDER REQUEST TO ADMINISTER MEDICAL MARIJUANA AT SCHOOL

Student's Name: ______________________________

DOB*: ____________ *Note: Medical marijuana can only be administered at school to a student under the age of 18.*

School: ____________________ Grade: __________ Teacher: ______________

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 nonsmokeable form

Dosage (amount): ______________________________

The medical marijuana must be administered during school hours: ☐ Yes ☐ No
If yes, time to be administered: ______________________________

Restrictions (including any restrictions on school activities for safety reasons) and/or important side effects: ☐ None anticipated
☐ Yes. Please describe in detail: ______________________________

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Date prescribed: ______________________________

Date to be discontinued: ______________________________

Any other necessary instructions or information: ______________________

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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 order, 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 MSAD 52 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: ____________________

Notes: ____

Adopted: March 2016