Alachua County Public Schools
Health Services

Authorization for Medical Marijuana/Low THC Cannabis

Use of Medical Marijuana for Qualified Students During School Hours

Void if Altered: Effective for the school year of 20____ / 20____

Student/Parent Information

Student Name:_____ Birthdate:_____ Allergies:_____ Grade:_____

Parent/Guardian Name: *(print or type)*_____

Address:_____

Home Phone:_____ Work Phone:_____ Other Phone:_____

Caregiver Name: *(print or type)*_____ Phone Number:_____

Caregiver Signature:_____ Registration ID Number:_____ Date:_____

Physician Name: *(print or type)*_____ Phone Number:_____

Address:_____ Fax Number:_____

Name of Medication:_____ Dosage:_____ Route:_____ Time:_____

Side Effects/Special Instruction:_____

_____

Has child displayed any signs and symptoms, adverse outcomes after receiving the medical marijuana? Yes ☐ No ☐

If Yes, please describe the signs, symptoms, or adverse reaction._____

_____

Physician's Signature:_____ Registration ID Number:_____ 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 disciplined based upon the District's Code of Student Conduct. I am also releasing Alachua County Public Schools from any liability that results in my son/daughter using, selling, or transmitting any of the medications identified above.

Parent/Guardian Signature:_____ Date:_____