Request/Permission to Administer Medical ~~Marijuana~~ Cannabis in School

Parent/Medical provider request to Administer Cannabis at School

Student's Name_____DOB_____
School_____Grade_____

(A) To be COMPLETED by the Physician, Certified Nurse Practitioner or Physician Assistant.

Reason for use of medical cannabis	
Form of medical cannabis (must be non smokeable/vapable form)	
Dosage, time and frequency	

The medical cannabis ***MUST*** be administered during school hours: ☐ Yes ☐ No

Any restrictions on school activities for safety reasons and/or important side effects:

☐ None anticipated ☐ Yes, Please describe:_____

_____

Provider's Signature	Date
PRINT Name	
Address	
Phone Number	

(B) To be completed by parent/guardian/legal custodian (designated "Primary Caregiver" under Maine Law for medical use of cannabis).

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 MSAD 11 School Board Policy JLCD

Signature	Date
Print Name	
Relationship	

NOTE: A **Copy** of the current written certification for the use of medical cannabis must be attached to this form.
Original written certification must be shown to school employee at time of processing request.

(C) To be completed by school:

Signature of Administrator	Date
Signature of Nurse	Date

Notes:

Adopted: August 8, 2019

Revised: February 1, 2024