



East Millinocket and Woodville School Departments

Eric W. Steeves Superintendent of Schools

Dawn C. Pray Assistant Superintendent of Schools

NEPN/NSBA Code: JLCDA

PARENT/MEDICAL PROVIDER REQUEST TO ADMINISTER MEDICAL MARIJUANA AT SCHOOL

Student's Name: _____ Grade: _____

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

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 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: _____

Date prescribed: _____ Date to be discontinued: _____

Any other necessary instructions or information:

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: _____



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Note: Any changes to the information 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 JLCDA – Administering Medical Marijuana to 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: _____

Checklist:

- _____ Original current certification was copied at school
- _____ Location of administration was discussed (main office)
- _____ Form has been reviewed for completion

Date reviewed: _____ Reviewed by: _____

Notes: