AUTHORIZATION FOR MEDICAL MARIJUANA/LOW THC CANNABIS USE FOR QUALIFIED STUDENTS IN SCHOOL

Lake Wales Charter Schools, Inc.

VOID if Altered

Effective for the School Year 20_____-20_____

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

Qualified Caregiver Information:		
Caregiver Name (Print):	Phone Number:	Registration ID Number:
Caregiver Signature:	Date:	

BELOW THIS LINE MUST BE FILLED OUT BY QUALIFIED PHYSICIAN:			
Physician Name (Print):		Registration ID Number:	
Address:		Phone Number:	
Name of Medication:	Dosage:	Route:	Time:
Special Instructions (To include reason must be given during school hours):			
Possible Side Effects:			
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:	