ATTACHMENT C

ADMINISTRATION OF MEDICAL CANNABIS AUTHORIZATION

The following forms are to assist caregivers and designated school personnel to properly administer medical cannabis to a public school student who has been issued a valid written certification for the use of medical cannabis in accordance with Health-General Article §13-3304, Annotated Code of Maryland.

- The medical cannabis must be in the original package and display the label provided by the licensed medical cannabis dispensary.
- The student's caregiver (parent/legal guardian or their designee, if applicable) must bring the medical cannabis to school.
- Any school personnel designated to administer the medical cannabis must call the certifying medical cannabis provider if a question arises about the student or the student's medical cannabis.

Instructions

School Administration of Medical Cannabis Form (page 2):

- This form must be completed for medical cannabis to be administered to a student on school property, during school-sponsored activities (including field trips and after-school activities), or on a school bus.
- The form must contain the most current dosing information to ensure the student receives proper administration, including instructions that describe the parameters of dosing at the therapeutic level of medical cannabis for the student's qualifying condition, and must be signed by the certifying provider issuing the written certification recommending the use of medical cannabis.

Changes to School Administration of Medical Cannabis Authorization Form (page 3)

- This form must be completed if any changes are made to the student's medical cannabis product, or frequency of administration during the school year.
- The parent/legal guardian must promptly provide this completed form to the school to ensure proper administration to the student.

Parent/Legal Guardian Authorization (page 4)

- The authorization must be completed and signed by the student's parent or legal guardian.

SCHOOL ADMINISTRATION OF MEDICAL CANNABIS AUTHORIZATION FORM

The Maryland Medical Cannabis Commission encourages Certifying Providers to complete this form in consultation with a Clinical Director at a licensed medical cannabis dispensary.

School Name:_____ School Year:_____

Location of School:		**Student's Date of Birth:**
Student's Name: Last	**First**	**Middle**
Type of Medical Cannabis and Strength: (To be completed by the Certifying Provider)		
Dosage to be Administered:	**Parameters of Dosing at the Therapeutic Level for Patient's Qualifying Condition:**	
Frequency or Time to be Administered:		
Route of Administration:	**Potential Side Effects:**	
Qualifying Condition (Reason Taken) and Symptoms:		**Student's MMCC patient ID #:**
Additional Notes or Directions:		
Printed Name of Certifying Provider (Last, First, MI)	**Signature of Certifying Provider:**	
Provider's Telephone Number:	**Provider's Fax Number:**	
Provider's Email Address:		**Date:**

Name of Clinical Director who consulted with the Certifying Provider, if any:	
Name of Dispensary:	**Dispensary's Telephone Number:**

CHANGES TO SCHOOL ADMINISTRATION OF MEDICAL CANNNABIS AUTHORIZATION FORM

The Maryland Medical Cannabis Commission encourages Certifying Providers to complete this form in consultation with a Clinical Director at a licensed medical cannabis dispensary.

Name and Location of School:		**Student's Date of Birth:**
Student's Name: Last	**First**	**Middle**
Effective Date of Change:		
Name of Medical Cannabis Product and Strength: (To be completed by the Certifying Provider)		
Dosage to be Administered:	**Parameters of Dosing at the Therapeutic Level for Patient's Qualifying Condition:**	
Frequency or Time to be Administered:		
Route of Administration:	**Potential Side Effects:**	
Qualifying Condition (Reason Taken) and Symptoms:		
Additional Notes or Instructions:		
Printed Name of Certifying Provider:	**Signature of Certifying Provider:**	
Telephone Number of the Certifying Provider:		
Printed Name of Clinical Director who consulted with the Certifying Provider, if any:		
Telephone Number of the Clinical Director:	**Name of the Dispensary:**	