

### Students

#### **Exhibit - School Medication Authorization Form- Medical Cannabis**

To be completed by the child's parent(s)/guardian(s). A new form must be completed every school year. Keep in the school nurse's office or, in the absence of a school nurse, the Building Principal's office.

Student's Name: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Address: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_  
School: \_\_\_\_\_ Grade: \_\_\_\_\_ Teacher: \_\_\_\_\_

To be completed by the student's physician, a physician assistant with prescriptive authority, or advanced practice RN with prescriptive authority:

Prescriber's Printed Name: \_\_\_\_\_  
Office Address: \_\_\_\_\_  
Office Phone: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_  
Medication name: \_\_\_\_\_  
Purpose: \_\_\_\_\_  
Dosage: \_\_\_\_\_ Frequency: \_\_\_\_\_  
IDPH registry ID card for student is valid [insert dates] \_\_\_\_\_  
IDPH registry ID card for designated caregiver is valid [insert dates] \_\_\_\_\_

***Attach copies of both registry identification cards.***

Time medication is to be administered or under what circumstances:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Prescription date: \_\_\_\_\_ Order date: \_\_\_\_\_ Discontinuation date: \_\_\_\_\_

Diagnosis requiring medication: \_\_\_\_\_

Is it necessary for this medication to be administered during the school day?  Yes  No

Expected side effects, if any: \_\_\_\_\_

Time interval for re-evaluation: \_\_\_\_\_

Other medications student is receiving: \_\_\_\_\_  
\_\_\_\_\_

Prescriber's Signature: \_\_\_\_\_ Date \_\_\_\_\_

***For only parents/guardians of students who want to grant their child permission to self-administer a medical cannabis infused product under direct supervision by a school nurse or administrator:***

I grant permission for my child to self-administer his or her medical cannabis infused product required under an asthma action plan, an Individual Health Care Action Plan, an allergy emergency action plan, a plan pursuant to Section 504 of the federal Rehabilitation Act of 1973, or a plan pursuant to the federal Individuals with Disabilities Education Act. 105 ILCS 5/10-22.21b, amended by P.A. 103-175. I understand that my child's self-administration will only occur under direct supervision by a school nurse or school administrator. 105 ILCS 5/22-33(b-5),.

Medical cannabis infused product child is permitted to self-administer:

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***Please initial to indicate (1) receipt of this information, and (2) authorization for your child to self-administer a medical cannabis infused product.***

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Parent/Guardian Initials

By signing below, I acknowledge, understand and agree as follows:

1. The only individual(s) who may possess and administer medical cannabis to my child at school or on the school bus is: a) his/her registered designated caregiver as identified by the Ill. Dept. of Public Health (IDPH); or b) a school nurse or school administrator.
2. Both my child and his/her registered designated caregiver possess valid registry identification cards issued by the IDPH, copies of which I have provided/will provide to the District.
3. After administering the medical cannabis to my child, the designated caregiver shall immediately remove the product from school premises or the school bus.
4. The designated caregiver may not administer a medical cannabis infused product in a manner that, in the opinion of the District or school, would create a disruption to the school's educational environment or would cause exposure of the product to other students.
5. Children under age 18 cannot smoke or vape medical cannabis. Medical cannabis-infused products include oils, ointments, foods, and other products that contain usable cannabis but are not smoked or vaped.

- 6. The District reserves the right to restrict or otherwise stop allowing the administration of medical cannabis to my child if the District or school would lose federal funding as a result.
  
- 7. I agree to indemnify and hold harmless the School District and its employees and agents against any claims, except a claim based on willful and wanton conduct, arising out of the administration of medical cannabis that I authorize by my signature below.

Parent/Guardian Printed Name \_\_\_\_\_

Address (if different from Student's above): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Emergency Phone: \_\_\_\_\_

\_\_\_\_\_  
Parent/Guardian Signature

\_\_\_\_\_  
Date