

**Administration of Medical Marijuana to Qualified Students**  
(Written Plan)  
Administration by Volunteer Personnel

To be completed by the student's parent or guardian

Name of qualified student \_\_\_\_\_

School \_\_\_\_\_ Grade \_\_\_\_\_

Name(s) of student's primary caregiver(s)

\_\_\_\_\_

\_\_\_\_\_

Primary caregiver's phone(s) \_\_\_\_\_

\_\_\_\_\_

Name(s) of volunteer school personnel

\_\_\_\_\_

\_\_\_\_\_

Permissible form of medical marijuana to be administered to the qualified student by the designated volunteer school personnel \_\_\_\_\_

\_\_\_\_\_

Administration method to be used by the designated volunteer school personnel (to assist the school district in determining an appropriate location for administration of medical marijuana to the student) \_\_\_\_\_

\_\_\_\_\_

Dosage amount \_\_\_\_\_

Proposed times to administer \_\_\_\_\_

Secure storage location \_\_\_\_\_

By initialing the following paragraphs and signing below, the undersigned parent(s) or guardian(s) hereby acknowledges:

\_\_\_\_\_ I have read and agree to comply with the board's policy regarding the administration of medical marijuana to qualified students.

\_\_\_\_\_ I assume all responsibility for the provision and use of medical marijuana to my child.

\_\_\_\_\_ I grant permission for the designated volunteer school personnel to store, administer, or assist in the administration of medical marijuana to my child.

\_\_\_\_\_ I understand that the district, with my input, will determine a designated location and any protocols regarding the administration of medical marijuana to my child and that this plan does not allow for the administration of medical marijuana on federal property or any location that prohibits marijuana on its property.

\_\_\_\_\_ I understand that permission to administer medical marijuana in accordance with this plan may be revoked for the failure to comply with the board's policy on the administration of medical marijuana to qualified students or other applicable board policies.

By signing below, I hereby release the Monte Vista School District and its personnel from any legal claim which I now have or may hereafter have arising out of the administration of medical marijuana to my child.

Date \_\_\_\_\_

\_\_\_\_\_  
*Signature of parent or guardian*

\_\_\_\_\_  
*Signature of parent or guardian*

\_\_\_\_\_  
*Signature of qualified student (if capable)*

To be completed by the volunteer school personnel

Name(s) of volunteer school personnel

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

By initialing the following paragraphs and signing below, the undersigned volunteer(s) hereby acknowledges:

\_\_\_\_\_ I have read and agree to comply with the board's policy regarding the administration of medical marijuana to qualified students.

\_\_\_\_\_ I have read and understand the student's written plan for the administration of medical marijuana.

\_\_\_\_\_ I assume all responsibility for the administration of medical marijuana to the student and maintenance of the student's medical marijuana by ensuring that it is securely stored in the designated location when not in use.

\_\_\_\_\_ I understand that permission to administer medical marijuana in accordance with this plan may be revoked for the failure to comply with the board's policy on the administration of medical marijuana to qualified students or other applicable board policies.

Date \_\_\_\_\_

\_\_\_\_\_  
*Signature of volunteer*

\_\_\_\_\_  
*Signature of volunteer*

To be completed by the school

I have reviewed a copy of the student's registration from the state of Colorado authorizing the student to receive medical marijuana. The expiration date is \_\_\_\_\_.

After receiving input from the student's parent(s) or guardian(s), I have conditionally approved the designated volunteer school personnel to administer the permissible form of medical marijuana identified above in the following designated location(s):

\_\_\_\_\_  
\_\_\_\_\_.

Such administration must occur in accordance with the following protocol(s):

\_\_\_\_\_  
\_\_\_\_\_.

Date \_\_\_\_\_

\_\_\_\_\_  
*Name of School Nurse or Designee*

\_\_\_\_\_  
*Signature of School Nurse or Designee*