ALLOWAY TOWNSHIP SCHOOL DISTRICT
Alloway, New Jersey

Exhibit

FILE CODE: 5141.22
_____ Monitored
_X_ Mandated
_X_ Other Reasons

MEDICAL MARIJUANA

CONSENT FOR RELEASE OF MEDICAL INFORMATION

New Jersey Department of Health, Medical Marijuana Program
P. O. Box 360
Trenton, New Jersey 08625-0360

Student Name: _____ Date of Birth _____

Address _____

I understand that as the parent/guardian of the above-named student, I am not obligated to authorize disclosure of any information provided to the New Jersey Department of Health and that refusal to authorize disclosure shall in no way affect my rights or the rights of the above-named student to use medicinal marijuana.

I authorize the New Jersey Department of Health Medicinal Marijuana Program to disclose, to the school district, information verifying the registration and authorization status of the above-named student to use medicinal marijuana for a qualifying medical condition(s) pursuant to the *Compassionate Use Act*, *N.J.S.A.* 24:6I-1 *et al*. I understand that the disclosure may contain confidential health information pertaining to the student's medical diagnosis and treatment.

This consent is granted for the sole purpose of verifying the registration status and ongoing authorization of the student according to *N.J.S.A.*24:6I-1 *et al.* and for no other purpose.

Signature of student's parent/guardian _____

Relationship to Student _____

Date _____

Signature of the school nurse _____

Date _____

MEDICAL MARIJUANA

PRIMARY CAREGIVER CONSENT FOR RELEASE OF INFORMATION

New Jersey Department of Health, Medical Marijuana Program
P. O. Box 360
Trenton, New Jersey 08625-0360

Primary Caregiver Name: _____ Date of Birth _____

Address _____

Student Name: _____ Date of Birth _____

Address _____

I understand that as the primary caregiver of the above-named student, I am not obligated to authorize disclosure of any information provided to the New Jersey Department of Health and that refusal to authorize disclosure shall in no way affect my right to assist the above-named student in the use of medicinal marijuana.

I authorize the New Jersey Department of Health Medicinal Marijuana Program to disclose, to the school district, information verifying my registration and authorization status to assist in the above-named student's use of medicinal marijuana for a qualifying medical condition(s) pursuant to the *Compassionate Use Act*, *N.J.S.A.* 24:6I-1 *et al*.

This consent is granted for the sole purpose of verifying the registration status and ongoing authorization of the primary caregiver to assist in the use of medicinal marijuana according to *N.J.S.A.*24:6I-1 *et al.* and for no other purpose.

Signature of the primary caregiver _____

Relationship to Student _____

Date _____

Signature of the school nurse _____

Date _____