

ALBUQUERQUE PUBLIC SCHOOLS

Medical Cannabis Treatment Plan

To be completed by parent or legal guardian:

Name of "qualified student" as defined by NMAC 6.12.10.7(L):

School attending: _____ Grade: _____ School Year _____

Name of student's "primary caregiver" as defined by NMAC 6.12.10.7(J):

Primary caregiver's phone number:

Home: _____ Mobile: _____ Work: _____

Medical cannabis product to be administered to qualified student:

Permissible form of medical cannabis to be administered by parent/guardian/primary caregiver*, including level of THC and CBD:

Recommended dosage: _____

Proposed time(s) of administration: _____

Medical Cannabis Written Certification

To be completed by the "certifying practitioner" as defined by NMAC 6.12.10.7(C):

I, (_____), certify that I am the certifying practitioner who has recommended medical cannabis my patient, (_____); has a diagnosis of _____, which is a debilitating medical condition pursuant to the Lynn and Erin Compassionate Use Act, and it is my professional opinion the potential health benefits of medical cannabis use would likely outweigh the health risks for this patient.

Signature of certifying practitioner: _____ Date: _____

Signature of Parent/Legal Guardian _____ Date _____

Signature of Principal _____ Date _____

*Primary Caregiver as designated in the NM Medical Cannabis Program. Application required by state.