

**Exhibit**

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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.

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**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.

\_\_\_\_\_  
Primary Caregiver Printed Name

\_\_\_\_\_  
Relationship to Student

\_\_\_\_\_  
Primary Caregiver Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
School Nurse Signature

\_\_\_\_\_  
Date

First Reading:           October 30, 2017  
Second Reading:       November 20, 2017  
Adopted:                 November 20, 2017