

Caregiver Acknowledgement/Consent/Disclosure

Caregiver Information:

Name: _____ **Relation to Patient:** _____

Driver's License #: _____ **Phone Number:** _____

I agree to act as caregiver for _____, who is a qualifying patient for Louisiana medical marijuana recommendation.

I agree to only possess and distribute medical cannabis for the purposes of assisting the patient.

I have been informed of and understand that:

I must prevent children and adolescents from gaining access to medicinal cannabis because of potential harm to their well-being. I will store cannabis in locked cabinets to prevent anyone else from using it.

- I cannot consume, by any means, any medical cannabis that has been dispensed on behalf of the qualifying patient.
- Selling, providing, diverting, or transferring by any means medical cannabis to any person other than the qualifying patient for whom I serve as a designated caregiver is a felony punishable by Louisiana state law.
- Intentionally making a false statement to a law enforcement official about any fact or circumstance relating to the medical use of cannabis to avoid arrest or prosecution is a misdemeanor punishable by Louisiana state law; and if convicted I will be disqualified from further participation as a designated caregiver.

I will report any suspected serious health effects in the qualifying patient caused by medical cannabis by informing my physician or, should the effects be suspected as life threatening, bring the qualifying patient to the emergency room.

I acknowledge the information listed above and certify the information provided in this application is true and accurate to the best of my knowledge.

Care giver signature: _____ **Date:** _____