

Wo/Men's Alliance for Medical Marijuana

A public benefit organization

WAMMM

WAMMM PARTICIPANT PARENTAL CONSENT FORM

I, _____, am the parent / legal guardian
(print name) (circle one)

give my consent to the Wo/Men's Alliance for Medical Marijuana (WAMMM) to provide
_____ with their services.
(print name)

I understand that WAMMM provides services to benefit terminally and chronically ill people in the hope of lessening suffering.

I agree to release medical information regarding the status of my medical condition and offer to participate in research studies to the extent necessary and possible as long as I hold participant status in WAMMM.

I understand that WAMMM reserves the right to refuse service(s) to anyone and that at any time my participant status may be withdrawn. In the event that this occur, I understand that I have a right to request from the WAMMM Board of Directors within ten (10) days a review of my participant status.

I have read and agree to all the articles and sections regarding WAMMM as an organization and my participation in WAMMM.

Signed _____ Date _____
(participant parent or legal guardian signature)

_____ Intake by: _____
(print name)

*Please return to WAMMM