STATE OF HAWAII

DEPARTMENT OF HEALTH
4348 Waialae Avenue, #648
Honolulu, Hawaii 96816

Application # _____

329 Minor or Adult Lacking Legal Capacity Certification

SECTION B. This section MUST be signed by the primary caregiver(s) of minor applicant or of an adult lacking legal capacity.

*Please use the applicant's name **exactly** as it appears on their **valid** government-issued identification or birth certificate.*

Applicant's Name _____
Last First Middle Suffix

I, the applicant's caregiver, am the (mark one): ❍ Parent ❍ Guardian ❍ Legal Custodian

☐ **I certify** that I am the parent, guardian, or legal custodian of the applicant/patient; **and**

❍ I have sole legal authority to make health care decisions on behalf of the applicant/patient; **or**

❍ I share joint legal authority to make health care decisions on behalf of the applicant/patient with:

_____
(Name of individual with whom you share joint legal authority. Both persons with legal authority to make health care decisions MUST initial the applicable items and sign below.)

For joint legal authority, both Parents, Guardians, or Legal Custodians, as applicable, must initial below:

		The applicant's primary care physician/APRN, so named in this application, has explained the potential risks and benefits of the medical use of cannabis to me and the applicant.
(initial)	(initial)	
		I consent to allow the applicant to use medical cannabis.
(initial)	(initial)	
		I consent to serve as the primary caregiver for the applicant.
(initial)	(initial)	
		I agree to control the acquisition, dosage, and frequency of the medical use of cannabis by the applicant.
(initial)	(initial)	
		I consent to allow the applicant's primary care physician/APRN, so named in this application, to release any protected health information pertaining to the applicant's debilitating medical condition for the purpose of the registration for medical use of cannabis as set forth in chapter 329, part IX, HRS, to authorized agents of the Department of Health. This consent is valid for the duration of the applicant's medical cannabis registration card or until my written revocation of this consent. I understand that if I revoke my consent, the applicant's medical cannabis registration card will be revoked.
(initial)	(initial)	

Under penalty of perjury, I attest that all information submitted is true to the best of my understanding and that I have not intentionally furnished false or fraudulent information or omitted any information from this application. By signing this document, I acknowledge that I am subject to chapter 329, part IX, HRS, chapter 11-160, HAR, and all other applicable laws for the medical use of cannabis in the State of Hawaii. I understand that the applicant's registration as a qualified patient to use medical cannabis under Hawaii law may not protect me or the patient against arrest, prosecution, or conviction under federal law.

_____
Print name of Parent, Guardian, or Legal Custodian who is **Primary Caregiver** for the applicant/patient

_____
For JOINT LEGAL CUSTODY (if applicable), print Name of **second** Parent, Guardian, or Legal Custodian who may act as Primary Caregiver #2

_____ _____
Signature of Parent, Guardian, or Legal Custodian Date

_____ _____
Signature of second Parent, Guardian, or Legal Custodian Date