DELAWARE HEALTH AND SOCIAL SERVICES
Division of Public Health
Medical Marijuana Program

Pediatric Patient Responsible Party Form

PEDIATRIC (AGE 17 OR YOUNGER) PATIENT INFORMATION			
Name: *(Last, First, M.I.)*		☐ M ☐ F ☒ X	**Date of Birth:**
Address:			
Address: *(City, State, ZIP Code)*			

RESPONSIBLE PARTY INFORMATION			
Name: *(Last, First, M.I.)*		☐ M ☐ F ☒ X	**Date of Birth:**
Address:			
Address: *(City, State, ZIP Code)*			
Primary Phone:	☐ **Home** ☐ **Cell** ☐ **Work**	☐ Check this box if a confidential message may be left at this number.	
Secondary Phone:	☐ **Home** ☐ **Cell** ☐ **Work**	☐ Check this box if a confidential message may be left at this number.	
Relationship to Applicant:		☐ Check this box if confidential information may be shared by email.	
Email Address: ***(Optional)***			

RESPONSIBLE PARTY ATTESTATION STATEMENT

_____ *initial*	I hereby certify that all of the information provided on this application is true and accurate to the best of my knowledge.
_____ *initial*	I agree to notify the Medical Marijuana Program, in writing, within 10 days of any changes to the information provided.
_____ *initial*	I attest that I will not divert marijuana to any individual or entity that is not allowed to possess marijuana pursuant to Title 16 of the Delaware Code, Chapter 49A.

_____ Responsible Party Signature

_____ Date of Signature

AUTHORIZATION FOR RESPONSIBLE PARTY

I _____, (parent/guardian), hereby authorize the following person to be my child's Responsible Party for the Delaware Medical Marijuana Program.

Responsible Party Name: _____ Date of Birth: _____

This authorization will expire with the expiration of the patient's registry card and will need to be reauthorized with each renewal.

_____ Parent/Guardian Signature

_____ Date