LOW THC OIL
WAIVER
NON FDA APPROVAL AND UNKNOWN CLINICAL BENEFITS OF CANNABINOIDS AND THC CONTAINING PRODUCTS

PATIENT INFORMATION (TYPE OR PRINT LEGIBLY)

Patient's Last Name (must match ID)	Patient's First Name (must match ID)	Date of Birth
Patient Address		
Patient's Telephone:	Patient's Email Address:	

1. CAREGIVER INFORMATION (TYPE OR PRINT LEGIBLY)

Caregiver's Last Name	Caregiver's First Name	MInitial
Caregiver's Mailing Address		
Caregiver's Telephone:	Caregiver's Email Address:	

2. CAREGIVER INFORMATION (TYPE OR PRINT LEGIBLY)

Caregiver's Last Name	Caregiver's First Name	MInitial
Caregiver's Mailing Address		
Caregiver's Telephone:	Caregiver's Email Address:	

*Caregiver means the parent, guardian, or legal custodian of an individual who is less than 18 years of age or the legal guardian of an adult.

_____ (NAME OF PATIENT) has been diagnosed with and is currently undergoing treatment for: (**MARK ALL THAT APPLY**)

- ___ Cancer, when such diagnosis is end stage or the treatment produces related wasting illness or recalcitrant nausea and vomiting
- ___ Amyotrophic lateral sclerosis, when such diagnosis is severe or end stage
- ___ Seizure disorders related to diagnosis of epilepsy or trauma related head injuries
- ___ Multiple sclerosis, when such diagnosis is severe or end stage
- ___ Crohn's disease
- ___ Mitochondrial disease
- ___ Parkinson's disease, when such diagnosis is sever or end stage
- ___ Sickle cell disease, when such diagnosis is severe or end stage
- ___ Tourette's syndrome, when such syndrome is diagnosed as severe
- ___ Autism spectrum disorder, when (a) patient is 18 years of age or more, or (b) patient is less than 18 years of age and diagnosed with severe autism
- ___ Epidermolysis bullosa
- ___ Alzheimer's disease, when such disease is severe or end stage
- ___ AIDS when such syndrome is severe or end stage
- ___ Peripheral neuropathy, when symptoms are severe or end stage
- ___ Patient is in hospice program, either as inpatient or outpatient

By signing below, I attest that I have been advised by _____
(Name of Physician)
that the use of cannabinoids and THC containing products have not been approved by the FDA and the clinical benefits are unknown and may cause harm. I am voluntarily agreeing and consenting to treatment through the use of cannabinoids and THC containing products and waive any rights to actions against the physician and the State of Georgia for the use of cannabinoids and THC containing products.

_____ _____
Patient or Caregiver's Name Patient or Caregiver's Signature

_____
Date signed

I have witnessed the free consent and signature of the patient/caregiver.

Affix the Notary Seal/Stamp in this space

Sworn and subscribed to me this _____ day of _____ in the year _____.

Signature of Public Notary: _____

My Commission Expires: _____