Central Community School System
Drug Testing Authorization

Student Name: _____

Parent/Guardian Name: _____

Parent/Guardian Phone Number: _____

I understand fully that my performance in extracurricular activities and the reputation of my school are dependent, in part, on my conduct as an individual. I recognize and understand that I could be asked to provide a hair sample for drug analysis. I consent to any such testing conducted as part of the Central Community School System drug testing policy, which is under the guidance and direction of
I agree that I will not refuse to take any such test or otherwise dispute the right of Central Community School System to conduct any such test(s) on me. I have been given the right to ask questions about the drug testing policy and I fully understand its provisions.

Listed below are the prescription drugs and dosages my son/daughter takes on a permanent basis. I understand that, depending on the type of medication and the circumstances, its use may have to be verified and discussed with the doctor that prescribed it. I give permission to the doctor(s) who have prescribed medication for the treatment of my son/daughter's medical condition. They may also verify the circumstance and discuss any effects that the medication may have on my son/daughter's test results or school performance.

_____ _____

Drug Name/Dosage **Doctor /Phone #**

_____ _____

Drug Name/Dosage **Doctor/Phone #**

Yes / No My son/daughter does not take any prescription medication on a regular basis.
Please Circle

_____ _____

Student Signature **Date**

Social Security Number _____ - _____ - _____

_____ _____

Parent Signature **Date**