

ARANSAS PASS INDEPENDENT SCHOOL DISTRICT
EXTRACURRICULAR DRUG TESTING AUTHORIZATION FORM

Print Student's Last Name:

First Name:

Student School ID #:

Grade of current school year:

Print Parent/Guardian's Name:

Date: _____

I acknowledge that I have received a copy of the Aransas Pass Independent School District Extracurricular Drug Testing Policy. I understand that I will be asked to provide a sample for drug analysis. I consent to any such testing conducted as part of the drug testing policy, and I agree that I will not refuse to provide a sample for drug analysis, if requested by the Aransas Pass Independent School District.

Student's Signature:

Parent/Guardian's Signature:

*Parent/Guardian DOB: _____ / _____ / _____

OR

Parent/Guardian LAST four digits of Social Security Number: _____

Information is needed to allow Medical Review Officer (MRO) to verify person contacted is parent / guardian concerning test irregularities or results.

NOTE: THIS DOCUMENT IS VALID FOR THE 20____ TO 20____ SCHOOL YEAR

REVISED August 2013