IOLA INDEPENDENT SCHOOL DISTRICT

Drug Testing Authorization

(Adopted August 21, 2006)

Student's Name: _____ Grade: _____ Date of Birth: _____

Parent/Guardian's Name: _____

Parent/Guardian's Phone Number: _____
Home Work

STUDENT ACKNOWLEDGEMENT

I acknowledge that I have received a copy of the Iola ISD Drug Testing Policy. I recognize and understand that I could be asked to provide a urine sample for drug analysis. I consent to any such drug testing conducted as part of the Iola ISD Drug Testing Policy, which is under the guidance and direction of the Compliance Consortium Corporation. I agree that I will not refuse to take any such test(s). I have been given the right to ask questions about the drug testing policy and I fully understand its provisions.

Student's Signature _____ Date: _____

PARENT ACKNOWLEDGEMENT

I acknowledge that I have received a copy of the Iola ISD Drug Testing Policy. I recognize and understand that my son/daughter could be asked to provide a urine sample for drug analysis. I consent to any such drug testing conducted as part of the Iola ISD Drug Testing Policy which is under the guidance and direction of the Compliance Consortium Corporation.

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 who prescribed it. I give permission to the doctor(s) who have prescribed the medication for the treatment of my son/daughter's medical condition(s) to verify the circumstances and discuss any effects that the medications(s) may have on my son's/daughter's lab results or school performance.

Drug Name: _____ Dosage: _____

Drug Name: _____ Dosage: _____

_____ My son/daughter does not take any prescription medication on a permanent basis.
Parent/Guardian's Initial's

Parent's/Guardian's Signature _____Date: _____

STUDENTS WHO DO NOT RETURN THE AUTHORIZATION FORM BY THE DATE INDICATED WILL NOT BE PERMITTED TO PARTICIPATE IN ANY EXTRACURRICULAR OR CO-CURRICULAR ACTIVITES OR PARK ON SCHOOL PROPERTY.

REFUSAL TO BE TESTED

I do not consent to my son/daughter being drug tested as part of the Iola ISD Drug Testing Policy. I acknowledge that I have received a copy of the Iola ISD Drug Testing Policy. I understand that my son/daughter will not be able to participate in or attend any extracurricular activities or drive on campus as outlined in the Iola ISD Drug Testing Policy.

Parent's/Guardian's Signature _____Date: _____