

ARANSAS PASS INDEPENDENT SCHOOL DISTRICT

EXTRACURRICULAR DRUG TESTING AUTHORIZATION FORM

NOTE: THIS DOCUMENT IS VALID FOR THE 2018 TO 2019 SCHOOL YEAR

Print Student's Last Name: _____ First Name: _____ Birthday: _____

Student School ID #: _____ Grade in 2018-2019 school year: _____

Print Parent/Guardian's Name: _____

Date: _____

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.