Wills Point ISD Drug Testing Authorization

Student's Name: ______________________________

Student's ID Number: __________________________

Parent/Guardian's Name: _____________________________

Parent/Guardian's Phone Number: ____________________Date: _______________

I acknowledge that I have received a copy of the Wills Point ISD Drug Testing Policy. I recognize and understand that I will be asked to provide a urine sample for drug analysis. I consent to any such testing conducted as part of the Wills Point ISD drug testing policy, and may be asked more than one time during the year. I agree that I will not refuse to take any such test or otherwise dispute Wills Point ISD's right 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.

Student Signature _____________________________

Listed below are the prescription drugs and dosages my son/daughter takes on a permanent basis. I understand that, depending upon 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 gave medication for the treatment of my daughter/son's medical condition(s) to verify the circumstance and discuss any effects that the medication(s) may have on my son/daughter's lab test results of school performance.

Drug Name:__________________________________Dosage:____________________

My son/daughter does not take any prescription medication on a permanent basis.

Parent/Guardian's Signature: ___________________________

Note: This document will be valid during the student's athletic, band, drill team, and cheerleader participation.