RAINS INDEPENDENT SCHOOL DISTRICT

RANDOM DRUG TESTING AUTHORIZATION FORM

Student's Name (Print): _____

Parent/Guardian Name (Print): _____

Date: _____

I acknowledge that I have received a copy of the Rains ISD Random Drug Testing Policy. I recognize and understand that if my child participates in extracurricular activities or parks a vehicle on school property he/she will be asked to provide a urine sample for drug analysis and could be randomly selected to provide another urine sample during the school year. I consent to any such testing conducted as part of the District's drug testing policy. 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 drug(s) and dosage(s) that my son/daughter takes on a permanent basis:

Drug Name _____ Dosage _____

Drug Name _____ Dosage _____

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

CONSENT FOR TESTING:

_____ _____

(Student's Signature) (Date)

_____ _____

(Parent/Guardian Signature) (Date)