BISHOP CHATARD HIGH SCHOOL

DRUG SCREENING AUTHORIZATION

Date: ______________________________

Student's Name: ____

Year of Graduation: _____________

Address: ____

City, State, Zip: ____

Parent/Guardian Phone Number: ____

I authorize *Indiana Testing Inc.* to perform a hair follicle drug screening on my child, _______________________________________, and agree to cover the cost of this screening.

I agree to submit the results to Bishop Chatard High School as soon as I receive them. I understand that a positive drug screening may result in denial of acceptance to Bishop Chatard High School.

____ ________________________
Parent/Guardian Signature Date

____ ________________________
Student Signature Date