# BISHOP CHATARD HIGH SCHOOL

**5885 Crittenden Ave., Indianapolis, IN 46220 • 317-251-1451 • 317-254-5427 (fax)**

## DRUG SCREENING AUTHORIZATION

DATE: _____

STUDENTS 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 SIGNATURE _____ DATE _____

STUDENT SIGNATURE _____ DATE _____

**Bishop Chatard High School**
**Office of Admissions**
**5885 Crittenden Ave.**
**Indianapolis, IN 46220**
**317-251-1451 x2267 (office)**
**317-254-5427 (fax)**