ARGYLE INDEPENDENT SCHOOL DISTRICT
DRUG-USE TESTING CONSENT FORM

Student's Full Name (Last name, First name, Middle name)

I understand after having received and read Argyle ISD Policy FNF(LOCAL) concerning student drug and alcohol testing that AISD will enforce this policy out of concern for my safety and health. I realize that the personal decisions that I make daily in regard to the use of illegal drugs and/or alcohol may affect my health and well-being as well as the possible endangerment of those around me and reflect upon any organization with which I am associated.

Signature of Student and Date

I have received, read and understand AISD Policy FNF(LOCAL) concerning student drug and alcohol testing. I understand that it is the practice of the district to conduct drug and/or alcohol tests for the purpose of carrying out this policy. I desire that my child named above participate in and be subject to the terms of the drug use testing program. I understand that I may withdraw this request for participation at any time in writing to the campus principal. I further understand and accept that if I withdraw my consent after my child has been selected for drug testing or if my child refuses to take the drug test he/she will be unable to participate in the above mentioned activities. If my child later decides to participate in extracurricular activities offered by AISD, and/or drive on AISD property, my child will be unable to participate in the above mentioned activities until such test is taken. I accept the method of obtaining urine and/or hair samples, testing of such samples, and all other aspects of the program.

I authorize the employees of AISD to release my child's student identification number, and biological specimens to Pinnacle Diagnostics & Laboratories, I authorize the officers, employees, and agents of Pinnacle Diagnostics & Laboratories and the district to communicate among themselves for official purposes, my child's drug and/or alcohol test results both orally and in writing, and to communicate such test results at any district administrative proceeding. I also authorize the officers, employees, and agents of Pinnacle Diagnostics & Laboratories and the district to have continued access to my child's biological specimens for the purpose of any further analysis or study that may be necessary, and require the results be communicated to me prior to any district administrative proceedings.

Parent/Guardian Signature and Date

Printed Name of Parent/Guardian

Witness Signature and Date

Printed Name of Witness and Date