The Center for Sports and
Occupational Medicine

ALCOHOL, DRUG AND / OR NICOTINE TEST
DISCLOSURE FORM

STUDENT: ______________________________ DATE: ______________

AUTHORIZATION: The undersigned does hereby authorize and direct to Katherine Shaw Bethea Hospital, Dixon, Illinois 61021, (hereinafter "KSB"), to disclose and release to Oregon Community Schools the results of the alcohol, drug and/or nicotine test performed upon ________________ (name) by KSB on ____________ (date). I understand and recognize that KSB has no control over the information relating to said results once they are released to Oregon Community Schools.

____________________ DATE

____________________ PARENT / GUARDIAN SIGNATURE

I ____________________ consent to have an alcohol, drug and / or nicotine test performed upon me by KSB on ____________________.
DATE

____________________ STUDENT SIGNATURE

____________________ WITNESS SIGNATURE