



ST. JOHNSBURY ACADEMY

St. Johnsbury Vermont, 05819 | Phone: (802) 748-8171 | Fax: (802) 748-5463 | www.stjohnsburyacademy.org

Student Name _____

Consent to Drug Test / Release of Medical Information

I/we understand that our student may receive disciplinary action, including suspension and/or expulsion from St. Johnsbury Academy. Therefore, I/we hereby give consent for said student's urine and/or blood to be obtained for drug/alcohol testing. I also give permission for Northeastern Vermont Regional Hospital to release aforementioned test results to the Headmaster of St. Johnsbury Academy and shall hold said hospital and healthcare providers at said hospital harmless and release them from any liability in performing said test and release of the results.

X

STUDENT SIGNATURE _____

DATE _____

PRINTED NAME OF STUDENT _____

X

PARENT/GUARDIAN SIGNATURE _____

DATE _____

PRINTED NAME OF PARENT/GUARDIAN _____