Consent for Treatment
Drug Use Testing Program – Big Sky Schools

I, _____ hereby consent to the collection of hair or saliva specimens, testing, and
Student Name
analyses of such specimens at Big Sky Medical Center (BSMC) for my entire high school career (grades 9-12).

I understand that the patient care may be under the control of an independent physician and BSMC is not liable for acts or omissions by an independent physician provided they have followed the instructions of said physician(s).

I certify that I have read the above information and as the student/patient, or one who is duly authorized to act in a representative capacity for the student/patient, that the information has been fully explained, that I understand its content, that it may not be modified and that I may withdraw my consent for drug use testing at any time.

Student Name (Printed)_____

Student Signature: _____ Time: _____ Date: _____

Parent Signature: _____ Time:_____ Date:_____