University of Missouri Student Health Center

Agreement to Submit to a Pre-Participation Urine Drug Test

I understand that my participation in clinical rotations is conditional upon successful completion of a urine drug test. I further acknowledge that failing this drug test may result in consequences as determined by my academic program. I further understand that my refusal to cooperate in any way with the drug testing procedure will also be grounds for withdrawal of my participation in clinical rotations.

I authorize the release of the results directly to the Student Health Center, who will release the results to my academic program who need to know the results for evaluating my suitability for clinical experiences. I understand that these results will be confidential to the extent possible and will not be released to a third party.

I agree to hold the University of Missouri and any affiliated or related facilities or entities and their respective officers, directors, employees, agents and servants harmless for their use of the results of these tests and the release thereof to any person or entity within the University of Missouri.

I acknowledge and agree that the sample given by me shall become the property of the Student Health Center, any affiliated or related facilities or entities and I hereby relinquish all rights to ownership and possession thereof.

I have listed below all prescription and over-the-counter medications taken within the last week, as well as the name, address, and phone number of the provider who prescribed the drug(s) listed. If no medications have been taken, I have checked the box below.

Medication(s) taken: ☐ NONE	Provider's Name/Address/Phone Number:
_____	_____
_____	_____
_____	_____

I ___ have/___have not (check one) been treated by a dentist or ear, nose and throat doctor (ENT) within the last week. If so, the date(s) of treatment is/are as follows: _____

By placing my written signature below, I attest to the accuracy of the foregoing, authorize the Student Health Center to contact my physician regarding the medications taken, and agree to be bound by the terms of this consent. I further certify that I have read and understand the foregoing, have had an opportunity to ask questions and agree to submit to the pre-participation urine drug test.

_____	_____
Student's Name (Printed)	Student's Academic Program
_____	_____
Student's Written Signature	Last 4 digits of student's SSN
_____	_____
Date	Student Number

There are four ways you can submit your form:

- **Mail:** Student Health Center, University of Missouri,
  Attn: Immunization Policy, 1020 Hitt St.,
  University Physicians Medical Bldg., Columbia, MO 65201
- **Fax:** (573) 884-8902
- **Email:** Scan and email form to immunizations@health.missouri.edu.
- **Drop off:** You can stop by the Health Center at the above location and hand your forms to the immunizations staff during business hours.

04/2015
500