Muskingum University Department of Nursing

Appendix A. Drug Testing Student Certification, Release, and Authorization Form

I, __________________________________________, ______________________________ hereby affirm that I have
(Student Name Please Print) (Student ID #)

read and understand this Drug Testing policy for Students in the Department of Nursing, and
that I have had an opportunity to ask responsible Department officials any questions I may have
about the policy.

I hereby give my consent to any person, agency or organization conducting any test or providing
any treatment or other service pursuant to this policy to provide information on the results of
such test, treatment or other service directly to the Chair of the Department of Nursing or the
Chair’s designated representative.

_____________________________  ______________________
Student Signature              Date

_____________________________
Witness Signature

_____________________________
Date
Muskingum University Department of Nursing
Drug Testing

Appendix B. Declaration of Legal Use of Prescribed Medication Form

Date_________________________

I, __________________________________, am currently taking the following legal (Student Name Please Print) medication(s) prescribed for me by the Healthcare Provider noted.

<table>
<thead>
<tr>
<th>Medication (dose, frequency, route)</th>
<th>Healthcare Provider</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(If more space is needed, please continue below)

__________________________________________________  ____________________________
(Physician or Qualified Advanced Practice Nurse)  (Phone number)

The medication is prescribed for______________________________ and treatment will (Health Alteration)

be completed on __________________________. (If this is an ongoing, long term medication, say so.) (Date)

_________________________________________________________________________________

Student Signature