



# TOURO UNIVERSITY

C A L I F O R N I A

## STUDENT HEALTH CENTER

### DRUG SCREEN FORM

Date: \_\_\_\_\_

This is to confirm that the student named below must be scheduled for a drug screen as required by the rotation site(s) within \_\_\_\_\_ days of the start of the rotation.

Name of Student: \_\_\_\_\_ Student ID Number: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Program and Class: \_\_\_\_\_

Rotation Site: \_\_\_\_\_

#### **College/Program representative to fill out the portion below:**

**Initial here if the drug screen is from a REQUIRED rotation site:** \_\_\_\_\_

If the drug screen is requested by a REQUIRED rotation site, the drug screen cost will be covered by Touro University California.

**Initial here if the drug screen is from an ELECTIVE rotation site:** \_\_\_\_\_

If requested by an ELECTIVE rotation site, the student will assume financial responsibility for the cost of the drug screen and any other fees occurred from the lab.

By signing below, I acknowledge the above terms.

Approved by: \_\_\_\_\_ Print Name and Title: \_\_\_\_\_

Student signature: \_\_\_\_\_ Date: \_\_\_\_\_

Note: Please use only Black or Blue ink to fill out this form.

Revised: 02/26/2014

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