Northwest Pediatrics ADD/ADHD Medication Agreement

Date: _____

Patient Name: _____

DOB: _____

Your child has been diagnosed with Attention Deficit Disorder (ADD) or Attention Deficit Hyperactivity Disorder (ADHD). Medications used for treatment of ADD/ADHD are classified as stimulants and are tightly controlled by state and federal law. Your understanding and cooperation with the following guidelines are required for your child to receive medication for the treatment of their ADD/ADHD at Northwest Pediatrics.

Please initial in the left margin next to each bulleted point and sign at the end to indicate your understanding of this Controlled Substance Agreement.

____ I understand that the medication my child is prescribed is not a "cure" for ADD/ADHD. Rather, it controls the symptoms to allow my child to learn and function better in school and socially.

_____ Stimulant medication can result in tolerance and dependence. For this reason, I agree to give the prescribed medication to my child as discussed with the medical provider (MD/APRN/PA).

_____ I understand that after initiation of medication for ADD/ADHD, my child will be seen at Northwest Pediatrics for medication management and follow-up appointment within 30 days until optimal dose of medication is reached. Subsequent visits will be every 3-6 months for maintenance therapy, unless a change in dose or medication is made, in which case a follow-up visit will be required within 30 days until the optimal dose is again reached. Refill of medication prescribed for ADD/ADHD may not be made if these follow-up visits are not kept. These visits allow monitoring of growth, blood pressure, heart rate and screening for medication effectiveness and potential side effects.

_____ Requests for medication refills may be submitted when the patient has 7 days or less of medication remaining. Please allow at least 2 business days for the prescription to be electronically sent to the pharmacy.

_____ Stimulant medications are easily abused. I understand that it is my responsibility as a parent to safeguard this medication. I will notify Northwest Pediatrics if the medication is lost, stolen or rendered unusable. I understand that Northwest Pediatrics may not issue another prescription in this instance.

_____ I will not seek to obtain ADD/ADHD medications from any other source, including other providers, emergency department or clinics. I understand that in the event of suspected abuse or misuse of this prescription medication, Northwest Pediatrics may be required to take further action, which may include dismissal from the practice.

_____ A parent or adult with written permission to bring child to appointment must be present at visit.

Parent Signature: _____

Printed name of parent: _____