

Name: _____



Behavioral Health Program STIMULANT MEDICATION AGREEMENT FORM

Your child has been prescribed a *stimulant medication* for the treatment of **Attention Deficit Hyperactivity Disorder (ADHD)**. Stimulant medication is a controlled substance, which means that additional rules and laws apply when prescribing these medications that the client and the physician must both comply with to safely manage these medications. Please read this document carefully and initial each item acknowledging your consent to our policies.

1. _____ I understand that this medication has been prescribed for my child and my child only. I agree that I will only give this medication to the prescribed client. *(Giving or selling this medication to someone else is a crime/felony.)*
2. _____ I agree to give this medication only at the prescribed dose or as instructed.
3. _____ I agree to keep this medication in a secure place out of reach of anyone other than the parent or guardian. I will give my child the ability to keep and self-dispense this medication only if discussed with and approved by the provider.
4. _____ I agree to the provider's policy regarding appropriate office appointments for the prescribing and management of stimulant medications. I understand that my child will need to be seen within 4 weeks of any new medication prescription, or if changes are made to an existing treatment. I agree to schedule and keep follow-up appointments for prescription management every 3 months at a minimum.
5. _____ I understand that medication refills will be provided at office visits for ADHD management. *Please make sure your child's ADHD follow-up appointment is scheduled at an appropriate time BEFORE your child runs out of medication.*
6. _____ I understand that if a change to my child's medication regimen is requested, it will usually necessitate an office visit.
7. _____ I agree to not request medication refills on Saturdays, or through the on-call paging system. **FOR REFILL REQUESTS, PLEASE CALL 508-679-6833 x100 WITH AT LEAST 5 DAYS' NOTICE.**
8. _____ When my child's medication is out of stock at a given pharmacy, I understand that it is my responsibility to locate another pharmacy that has the medication and to request that an electronic prescription be sent only to that pharmacy where the medication is available.
9. _____ I agree to periodic urine drug test at the discretion of the prescriber, including coming in for random screenings if requested.

Thank you for taking the time to read and review these policies. We appreciate your partnership in making sure these medications are prescribed in a safe and lawful way.

Client (if 18 y.o.) or Parent/Guardian Signature:

Date:

Print Name:

Relationship to Client:

Mother / Father / Guardian / Self