
## Pediatric Associates, PSC Stimulant (ADHD Medication) Agreement

Date: _____

Patient Name: _____

Patient DOB: _____

Patient SS# or KY Drivers lic#: _____

**To the Parent or Patient:**

In accordance with 902KAR55:110, it is our policy at Pediatric Associates, PSC that patients (or their guardian) receiving prescriptions for controlled substances be required to sign a Controlled Substance Agreement.

By signing this agreement, I agree or I agree to follow for my child:

- I agree to take the medication **ONLY** as prescribed and I will not change the dose without getting approval from my physician or provider.
- I agree not to share, sell or otherwise dispense this medication to anyone else.
- I understand this medication has potential side effects including but not limited to: appetite suppression, headaches, stomach pain, irritability or other temporary behavior changes, and difficulty sleeping. These are less if the medications are prescribed to me in a controlled setting under close monitoring by my doctor or provider. This requires regular office visits to follow my progress.
- I know that this medication is given to help control the effects of ADHD. It is not a cure. The duration of use is determined by the effectiveness of the treatment.
- I understand this medication is potentially addictive and chances of addiction are less if the medications are prescribed to me in a controlled setting under close monitoring by my doctor or provider. This requires regular office visits to follow my progress.
- I agree that this medication will be stopped if my ability to function does not improve, if the medication loses its effectiveness, if I do not attend required office appointments, or if there is reason to believe I am misusing the medication in any way.
- I have had the risks associated with taking this medication explained to me and have decided that the benefits outweigh the risks.
- If I am unable to take the medication due to allergic or otherwise adverse reaction, I will notify the prescriber and discard the remainder.
- I understand that if any of this medication needs to be discarded I contact my local police department to locate a drug disposal location.
- I authorize Pediatric Associates, PSC to review medication information with other doctors, hospitals, and pharmacists.

_____ _____

Patient Signature Date

_____ _____

Parent Signature (if patient is under 18 years) Date