

MILESTONE PEDIATRICS

4043 S. Route 59
Naperville, IL 60564
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ADHD AGREEMENT

I understand my child has been prescribed medication for the treatment of ADHD. The risks and benefits have been reviewed and discussed with me.

I agree and/or I have been informed of the following:

- 1) I am aware my child will need an ADHD follow up office visit every **6 months or sooner (if indicated) with a physician and will call at least 24 hours in advance if I have to cancel.** This appointment is necessary so that your child's height/weight/blood pressure, response to medication and general well-being can be established and be regularly monitored.
- 2) **Prescriptions will NOT be given if the last ADHD appointment is greater than 6 months.**
- 3) I will request refills of my child's medication **at least 3 days prior to the last dose of the current prescription.** (NOTE: refills cannot be filled on weekends or during on-call hours)
- 4) I will administer my child's medication as prescribed and **not adjust dosage on my own** without advice from the physician.
- 5) I understand that **ADHD medications are controlled substances that are regulated by state and federal law** because of their high risk for abuse. I acknowledge that I am responsible for protecting my child's prescription and my child's medication from being lost, stolen or misused by other persons.
- 6) Milestone Pediatrics staff may request information from the Illinois Prescription Monitoring program on all controlled medications dispensed to my child to establish prescription history.

I understand and agree to all of the above.

Print name of Parent/Guardian

Child's name & Date of Birth

Signature of Parent/Guardian

Today's Date