Children's Health Partners (CHP) Stimulant Medication Agreement Form

Your child has been prescribed a stimulant medication for the treatment of attention deficit disorder or attention deficit hyperactivity disorder. **Stimulant medication is a controlled substance, which means that additional rules and laws apply when prescribing these medications that the patient and the physician must both comply with in order to safely manage these medications.** Read this document carefully and initial each item acknowledging your consent to our policies.

1. ____ **This medication has been prescribed for your child and your child only**. I agree that I will only give this medication to the prescribed patient. (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 to by CHP.

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 & approved by CHP.

4. ____ I agree to CHP'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 ADD/ADHD management. Please make sure your child's ADHD follow up appointment is scheduled at an appropriate time BEFORE your child will run out of medication**.

6. ____ I understand that combining ADHD/ADD follow-up with a yearly physical is at the discretion of the physician, and is only appropriate when the medication regimen is stable. Generally, **a separate ADHD follow up appointment is necessary**.

7. ____ I understand that if a change to my child's medication regimen is requested, it will usually necessitate an office visit.

8. ____ I understand that in the **rare** case that it is necessary for our office to prescribe a medication outside of an office visit, it will take 2-3 business days to accommodate this request. This exception is at the discretion of the prescribing physician.

9. ____Commonly, your child might receive 3, 1 month electronic prescriptions. I understand that I should call my pharmacy directly to have these prescriptions filled.

10. ____ I agree to **not request medication refills on Saturdays, or through the on-call paging system**.

11. ____ I understand the during times of medication shortage, CHP may need to provide paper prescriptions so that patients can locate and fill their prescriptions.

12. ____ During times that these medications are out of stock at certain pharmacies, I understand that it is my responsibility to locate my child's medication and to only request an electronic prescription at a pharmacy that has the medication in stock.

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.

Patient Name:_____ Patient DOB: _____

_____ (parent/guardian signature) _____ (date)

_____(patient signature, if >12 years) _____ (date)