Community Health Services
Your Partners for Better Health

PEDIATRIC AGREEMENT FOR LONG-TERM CONTROLLED SUBSTANCE PRESCRIPTIONS

_____/_____/_____
TODAY'S DATE

_____ _____/_____/_____
PATIENT NAME (PLEASE PRINT) DATE OF BIRTH

The use of (print names of medication(s)_____ is only one part of the treatment for:

(print name of condition—e.g., ADD/ADHD, pain, anxiety, etc.) _____.

_____ (provider name) will be my designated provider for this medication.

The goals of this medicine are:

- To help control the effects of my child's condition(s), stated above, as much as possible without causing dangerous side effects. I understand it is not a cure for ADD/ADHD.

The patient's parent or legal guardian must initial each statement after reviewing.

_____ The patient's provider has completed medication counseling which includes the following information:

1. The patient should not drink alcohol or use street drugs while on the above listed medication(s). If I become aware that my child is using these substances, I will notify their provider immediately. I also understand the treatment may be stopped.
2. Abuse of the medication can be dangerous, and the patient may get addicted to this medicine.
3. If the patient or anyone in their family has a history of drug or alcohol problems, there is a higher chance that the patient may become addicted.

As the patient's parent or legal guardian I understand, am responsible for and voluntarily agree that:

_____ The patient will keep, and be on time for, all their scheduled appointments with the designated provider.

_____ The patient will participate in all other types of treatment that they are asked to participate in.

_____ The medication will be kept safe, secure and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until the patient's next appointment, and may not be replaced at all.

_____ I will ensure that the medication is taken only as instructed and not change the way it is taken without first talking to the designated provider.

_____ The above prescription(s) will be filled only by the designated provider.

_____ I will make sure the patient has an appointment for refills. I understand that refills cannot be called in, faxed or mailed to the pharmacy.

_____ It is illegal to, and therefore will not, sell this medicine or share it with others. I understand that if I or my child does, the treatment will be stopped.

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_____ I will sign a release of records form to let the designated provider speak to all other doctors or providers that the patient may see. I will inform the designated provider of all other medicines that the patient takes, and let him/her know right away if the patient receives a prescription for a new medication.

_____ I will use only one pharmacy to fill the prescription for the above medication(s), unless the designated provider is notified ahead of time:

_____

PHARMACY NAME PHONE NUMBER

_____ I understand my child may be subject to random drug testing in office.

_____ I must make sure the office has current contact information in order to reach me, and that any of the patient's missed tests will be considered positive for drugs.

_____ If the designated provider determines that the risks of taking this medication are greater than the benefits, said provider will change the prescription to wean off, decrease this medication dose. or discontinue medication.

_____ If the designated provider recommends to treat the cause of the patient's conditions, as stated above, said provider will change the prescription to wean off or decrease the medication dose.

_____ The patient may lose their right to treatment in this office if I or the patient breaks any part of this agreement.

I, _____ (the designated provider), will help set treatment goals and monitor the patient's progress in achieving those goals. I will also work with any other doctors or providers the patient is seeing in order to treat them safely and effectively.

_____

PARENT OR LEGAL GUARDIAN NAME (PLEASE PRINT)

_____ _____/_____/_____

PARENT OR LEGAL GUARDIAN SIGNATURE TODAY'S DATE

_____

PROVIDER NAME (PLEASE PRINT)

_____ _____/_____/_____

PROVIDER SIGNATURE TODAY'S DATE