# Seattle University Student Health Center

Bellarmine Hall #108
1111 East Columbia Street, Seattle, WA 98122
Tel: (206) 296-6300

Patient's Name (printed): _____

Date of Birth: _____ SU ID: _____
Month Day Year

## ADHD MEDICATION AGREEMENT

I have been prescribed medication for the treatment of ADHD. I understand these medications are controlled substances and are tightly regulated by state and federal law with a high risk for abuse.

I understand that it is a **felony** to obtain these medications by fraudulent means, to possess these medications without a legitimate prescription, and to give or sell these medications to others.

I agree that my hometown or previous prescribing provider will be notified that my prescriptions are now going to be written by the Student Health Center ARNP. I also agree that my hometown or previous prescribing provider may disclose to the Student Health Center when prescriptions have been written for me in their office. I will not seek to have duplicate prescriptions written for me of the same medication.

I am aware that:

- A single prescription will be up to a 28-day supply.
- I will use my medication as prescribed and not adjust the dosage on my own.
- I will notify my provider of changes in my health or prescriptions that may impact ADHD treatment.
- I am responsible for filling and paying for my medications.
- My clinician requires medication follow-up visits at least once a month until the dose of medication is stable. Once the medication dose is stable the provider may transition me to follow-up appointments every 3 months.
- My clinician participates in Prescription Monitoring Programs, and I will not seek medication refills from other medical practices without their knowledge.
- If my appointments are not kept my prescriptions **will not be renewed.**
- If my prescription is lost, stolen, or damaged or the medication itself is misplaced, the prescription will not be rewritten before the 25-day renewal period, **no exceptions**.
- Urine drug screens will routinely be collected, and I am responsible for the cost of the test. Results may determine future treatment.

The mixing of ADHD medications with other substances, including illicit, legal, and prescription substances, can be unsafe. Prior to taking any new substances, prescribed, over-the-counter, or recreational, I understand that I must have a conversation with my prescribing provider about safety.

I acknowledge that violation of the Student Health Center policies concerning ADHD medications will result in termination by the Student Health Center of my prescription for those medications.

My signature below indicates that I have received and read this ADHD Medication Agreement and I understand it and I have been provided an opportunity to ask questions. I have all the information I want, all my questions have been answered, and I agree to fulfill my obligations under this Agreement.

Signature _____ Date _____