MISSOURI S&T | Student Health Services

Missouri S&T Stimulant (ADHD medication) CONSENT

Patient Name: _____
Patient DOB: _____
Patient Student ID #: _____

To the Patient:
It is our policy at Missouri S&T Student Health that patients receiving prescriptions for controlled substances be required to sign a Controlled Substance Agreement. By signing this agreement, I agree to follow:

- I agree that I (the patient) will take the medication ONLY as prescribed, and the dose will NOT be changed without getting approval from my physician or provider.
- I agree not to share, sell or otherwise dispense this medication to anyone else.
- I agree not to seek ADHD medicine from any other source, including other physicians, emergency departments, or clinics.
- I understand this medication has potential side effects including but not limited to appetite suppression, headaches, stomach pain, irritability or other temporary behavior changes, changes in blood pressure 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.
- I understand that after initiation of treatment, a follow up visit is required within 30 days, and then every 3 months after that. There are no exceptions to this rule. No refill of the medication prescribed for ADHD can be made if these follow-up visits are not kept.
- I understand that refills of the medication are authorized once every thirty days as long as the required follow-up office visits are kept. I will not be provided a refill prescription prior to this thirty-day period. Refill prescriptions cannot be mailed, faxed or called in to the pharmacy. The prescription must be picked up at the office by the patient.
- I understand that to obtain a refill, I must call the clinic Monday-Friday 8:00 am to 4:30 pm the day before the refill expires, to request a refill to be picked up the next day the office is open. It is important to make sure that the patient has enough medication to get through weekends, holidays, or after hours because the provider on call will not refill these prescriptions.
- I agree that only one pharmacy will be used to fill this ADHD medicine prescription:

  The pharmacy I have selected: _____
  Pharmacy Address: _____
  Pharmacy Phone Number: _____

- 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.

910 W. 10th Street | Rolla, Missouri 65409 | P: (573) 341-4284 | F: (573) 341-6967 | mstshs@mst.edu | studenthealth.mst.edu

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- 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 Missouri S&T Student Health to review medication information with other doctors, hospitals, and pharmacists; additionally, to contact any groups and organizations involved with my care and involved with the investigation of medication and drug abuse. I give permission to my provider to discuss my care with past caregivers, all pharmacies and policing agencies
- I agree to pay S&T Student Health a charge of $45 per semester to manage medications for ADHD
- I understand that if I break this agreement, my provider reserves the right to stop prescribing stimulant medications for me.

This consent will need to be signed annually.

_____ _____

Patient Signature Date

_____ _____

Physician Signature Date

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