Attention Deficit Disorder (ADD) therapy agreement

Name of child _____ Date of Birth of child _____

Name of Parent/Guardian _____

Please read and initial each statement

I agree that I will obtain ADD medications for my child only from a provider at VCC at this time. If I choose to seek care elsewhere for this health condition, I will inform my provider at VCC of such a decision.
_____

I understand the importance of giving the medication to my child at the dose and frequency prescribed by my physician. I agree not to increase the dose of the medication without first discussing it with my child's provider. _____

I will attend all reasonable appointments, as requested by my physician. I understand that it is my responsibility to make these regular appointments for my child and that medication refills without an appointment should not be expected. _____

I agree to be responsible for the secure storage of this medication / prescription at all times. I agree not to give or sell the prescribed medication to any other person. In the event of a stolen/lost prescription /medication, it is per the discretion of my provider to replace the medication. _____

I understand that I will be expected to complete assessment/progress questionnaires related to ADD and to obtain such completed questionnaires from my child's teacher on a periodic basis at the discretion of the provider. If I do not bring these questionnaires to my child's appointment, my child's medication refill may be delayed. _____

I understand that if I break this agreement, my physician reserves the right to stop prescribing stimulant medications for my child. _____

Children age 13 years and above must also read the above agreement and sign below:

I understand the above agreement is in reference to my prescription medication for ADD. I agree to abide by its terms and specifications.

Signature of child (13 years and above) _____

Signature of the parent/guardian _____ Date _____