AMERICAN UNIVERSITY
Student Health Center

OFFICE *of* CAMPUS LIFE

AU STUDENT HEALTH CENTER ADHD MEDICATION AGREEMENT

General Terms:

- I have been prescribed psycho-stimulant medication for treatment of ADHD or other condition(s). I understand that ADHD medications are controlled substances that are regulated by state and federal law because of their high risk for abuse.

- If I have an off-campus provider (e.g. pediatrician or psychiatrist), I understand and agree that the off-campus provider may disclose to American University Student Health Center (AU SHC) when prescriptions are, or have been, written for me in their office. I agree that my original prescribing provider can be notified when my prescriptions are written by the AU SHC. While receiving prescriptions from the AU SHC I will only receive prescriptions from an AU SHC provider unless I am away from the SHC for an extended time (e.g. summer break or study abroad)

- I will communicate with my AU SHC provider on a fully and timely basis about: the intensity of my symptoms, their effects on my daily life, the effectiveness of the medication in relieving my symptoms, and any significant side effects that occur. I understand that evidence of improved functioning is a requirement of continued treatment. If I am unable to tolerate any controlled medication or it is ineffective, I may be asked to bring in any unused medication to my clinician for proper disposal.

- I understand that it is a **felony** and is potentially very dangerous 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 understand that my provider recommends that I do not use alcohol and drugs with controlled substances and that combining controlled substances with alcohol or drugs can adversely affect my health.

Receiving Prescriptions at the AU SHC

- I understand that the prescription must be electronically prescribed for only one month at a time.
- I will be required to make a monthly appointment at AU SHC for follow-up consultation whether I am seeing a medical provider or a psychiatric provider.
- I will only use my medication as prescribed and not adjust the dosage on my own.
- I will have to make an appointment to get my ADHD prescription and cannot walk in for a refill.
- I will keep my appointment with SHC and will cancel my appointment no later than 2 hours prior to the appointment time if I can no longer keep it. Multiple missed appointments may result in the loss of ADHD prescription refills or privileges.
- Prescriptions will not be written before 14 days from the last appointment date.
- AU SHC staff may request information from Prescription Monitoring programs on all controlled medications dispensed to me to establish prescription history.

- I acknowledge that my provider may require a drug screening test before she or he provides a new prescription for my ADHD medication and I agree to cooperate with this screening. While this screening is voluntary and confidential, providers may elect to not prescribe a refill until they can receive the results of a drug screen. I understand that I may be responsible for fees associated with obtaining a drug screen.

Storage of ADHD Medications:

- I acknowledge that I am solely responsible for protecting my medications from being lost or misused by other persons.
- It is recommended that medications be locked in a personal safe and not placed in medication cabinets.

Stolen or Lost ADHD Medications

- If a prescription is lost, stolen, or damaged, or the medication itself is misplaced, I understand and agree that the prescription will not be rewritten unless one has a crime report from American University Police (if living on campus) or DC MPD (if living off-campus)
- I understand that even if my provider writes a replacement prescription, the pharmacy or my insurance company may not agree to fill the prescription.

Acknowledgement:

I understand that if I violate the terms of this Agreement, my provider may stop prescribing the medication(s) with the option to taper off the medication to avoid withdrawal symptoms, if this is necessary. I also understand that a drug dependence treatment program may be recommended.

I also acknowledge that the illegal or unauthorized possession, use, transfer, distribution or sale of drugs is prohibited by the American University's Student Conduct Code and can result in disciplinary action by the University up to dismissal from the University.

I agree to follow the terms of this Agreement. They have been fully explained to me. Any questions and concerns regarding this Agreement have been adequately answered. A copy of these policies is available on the AU SHC website or has been given to me.

By signing below, I have read and understood this contract and I agree to fulfill my obligations as described in this Agreement. I agree that this consent form may be electronically signed and that my electronic signature appearing on this consent form is the same as handwritten signatures for the purposes of validity, enforceability, and admissibility. I understand that I may opt-out of signing this document electronically by contacting the Student Health Center.

I understand that I may receive an electronic copy of this consent form by requesting it from SHC and providing my email address, and SHC will email the form to me. If I am unable to receive the form via email, I will notify SHC so that other arrangements can be made.

_____ _____

Print Name Date of Birth

_____ _____

Signature Date

_____ _____

Provider Signature **Date**