Student Health and Wellness Center (SHWC) Controlled Medication Agreement

Date: _____

Name of student: _____

Date of Birth of student: _____

In accordance with Student Health and Wellness Center's ADHD policy, I agree that I will not share, distribute, or sell the ADHD medication(s) prescribed to me by SHWC. Furthermore, I will not attempt to have another person fill my prescription for me. I agree to use the following local pharmacy as my sole pharmacy to obtain my ADHD controlled-substance medication(s):

Name of Pharmacy: _____

Pharmacy Address: _____

Pharmacy's Phone Number: _____

Furthermore, I have been made aware of the right of SHWC to perform periodic drug screenings while I am receiving SHWC-prescribed controlled-substance medications. I am aware that use of alcohol and/or illicit drugs is discouraged, especially while taking controlled-substance medications. SHWC reserves the right to terminate the prescribing of these medications if I fail a drug screen.

SHWC will respond to prescription medication requests within 48hrs (2 business days) of us receiving a request from patients. It is the patient's responsibility to request a refill and to do so before running out of their current medication.

I am aware of the risks of taking a controlled-substance stimulant medication including, sleep difficulties, agitation, cardiac symptoms and psychological and/or physiological dependence. If experiencing any side effects of my medication, I will alert my SHWC prescriber and/or seek immediate medical attention as appropriate.

_____ _____

Signature of Student *Date*

_____ _____

Signature of SHWC Clinician *Date*

_____ _____

Signature of Witness *Date*