CAL STATE EAST BAY

ADHD Medication and Controlled Substance Agreement

General Terms

_____I understand that all students receiving prescriptions for stimulant medications must review and sign the ADHD Medication and Controlled Substance Agreement.

_____I understand that controlled substances are regulated by state and federal law because of their high risk for abuse, dependence, tolerance, and potentially life-threatening withdrawal symptoms. I understand that if I adjust or stop my medication without consulting with the psychiatrist first I may experience serious medical and psychiatric consequences.

_____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, or to give or sell these medications to others.

_____I understand that I may be asked to bring in any unused medication for proper disposal.

_____I understand that the psychiatrist 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, including overdose, bodily injury, permanent medical issues, and death.

_____I understand that the psychiatrist may require a drug screening test before they prescribe controlled medication and I agree to cooperate with this. While this screening is voluntary and confidential, the psychiatrist may elect to not prescribe a controlled medication until they receive the results of a drug screen. I understand that I may be responsible for fees associated with obtaining a drug screen.

_____I agree to go to an emergency room or call 911 if I experience symptoms of stimulant overdose, including new tremors or change in existing tremors, seizures, restless or aggressive behavior, overactive reflexes, fast breathing, fast or irregular pulse rate, confusion, stomach cramps, or more serious symptoms such as heart attack or stroke.

_____I understand that I must Immediately dispose of unused or expired prescription stimulants properly or take them to a drug take-back site, location, or program.

_____I agree to talk to the psychiatrist if my use of prescription stimulants has resulted in problems with my health, relationships, responsibilities, or the law, or if I am struggling with misusing these or other medicines.

_____I agree to talk to the psychiatrist if I have questions or concerns about risks of taking prescription stimulants.

Prescriptions

_____I understand that meeting with the SHCS psychiatrist does not guarantee a prescription of or refill for stimulant medication and that if the psychiatrist has concerns regarding the safety of stimulant medications, or the validity of the ADHD testing or diagnosis, the psychiatrist may not refill or prescribe stimulants, and I may be referred for further evaluation.

_____While receiving prescriptions from the SHCS I will only receive prescriptions from the SHCS psychiatrist unless I am away from SHCS for an extended period of time (e.g. summer break or study abroad).

_____I agree to communicate with the SHCS psychiatrist on a timely basis about: my symptoms, effectiveness of the medication, and side effects.

_____I understand that my controlled substance medication may be a one-time prescription or short-term per the psychiatrist's clinical judgement and to reduce risk for addiction, dependence, tolerance, and withdrawal symptoms.

_____I understand that the prescription must be prescribed for only *one month at a time* and that I will be required to make a monthly appointment with the psychiatrist for follow-up consultation and refills. I cannot walk in, call or send a

secure message, for a refill. I will keep my appointment with the SHCS psychiatrist and will cancel my appointment 24 hours in advance. If I cancel or miss an appointment, my medication may not be refilled. Multiple missed appointments may result in the loss of prescriptions.

_____I understand I will only use my medication as prescribed and not adjust the dosage on my own. Non-compliance may result in the loss of prescription refills or privileges.

_____I understand that the SHCS psychiatrist will request information from Prescription Monitoring programs on all controlled medications dispensed to me to establish prescription history.

Stolen or Lost Controlled Medications

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

_____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 CSUEB Campus Police (if living on campus) or my local police department (if living off-campus).

_____I understand that even if the psychiatrist 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, the psychiatrist may stop prescribing the medication(s) with the option to taper off the medication to avoid withdrawal symptoms, if this is necessary. I understand that a drug dependence treatment program may be recommended. I acknowledge that the illegal or unauthorized possession, use, transfer, distribution or sale of drugs is prohibited by the Cal State University's Student Conduct Code and can result in disciplinary action by the University. By signing below, I have read, understood, and agree to this Agreement.

Student printed name_____NetID_____

Student signature_____Date_____