McLaren Business Products

**McLaren Print System Order**

**Order No: 43421 Reprint Previous Order No: 5608**
**Order Date: 2019-03-07**
**User: Katie Jacobs**
**Phone: 9898263271**

**Ship Location: Main Street Family Practice-Amy James**
**117 S Burgess Street**
**West Branch, Michigan 48661**
**Forms**
**Quantity: 500**
**Paragon Dept No: 69990**
**Dept Name: McLaren**
**Company Number: 810**

**Order Total Price: 0.00**

**Item Number: MM-170**
**Item Description: Parent Controlled Medicines Agreement**
**Revision Date: 5/2017**
**Print: 1 sided black and white**
**Paper: 20# White Text**
**Size: 8.5 x 11**
**Fold:**
**Finish:**
**Drill: None**
**Misc Info:**

McLaren Medical Group
PARENT CONTROLLED MEDICINES AGREEMENT

**The purpose of this Agreement is to prevent any misunderstandings about certain medications that your child will be taking. This is to assist both you and your doctor in complying with the law regarding controlled medicines.**

**TERMS OF AGREEMENT:**

I understand that my child's doctor is bound by certain state and federal laws when prescribing controlled medicines. While these laws seem inconvenient to me, I understand that they are ultimately intended to protect my child's safety, health, and privacy.

I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship. I understand that if I break this Agreement, my child's doctor will stop prescribing controlled medicines for my child.

I understand that this agreement includes all controlled medicines scheduled II-V as categorized by the U.S. Federal regulations. This may include, but is not limited to, drugs referred to as Narcotics, ADD/ADHD Medications, Sleep Medications, Benzodiazepines, etc.

I will communicate with my child's doctor about the character and intensity of my child's symptoms, the effect of the symptoms on my child's daily life, and how well the medicine is helping to control the symptoms.

I will be vigilant in assuring that my child does not use any illegal controlled substances, including marijuana, cocaine, etc., or prescription drugs not prescribed to my child, and agree that my child may be tested for use of controlled substances at any time.

I will not use, share, sell, or trade my child's medication at any time.

I agree that I will administer the medication exactly as the doctor prescribed it and make no changes to the dose, nor discontinue the medication, without instruction from my child's doctor.

I will not attempt to obtain any controlled medications for my child from any other doctor without coordination of care between doctors.

I agree to use _____ pharmacy, located at _____, for filing prescriptions for all of my child's controlled medicines.

I will safeguard my child's prescription and my child's medication from loss or theft. I understand that my child's doctor may not replace lost, misplaced, or stolen medicines. If I have trouble with safeguarding my child's medicine, I understand my doctor will discuss this with me and may elect to remove my child from therapy with controlled medicines.

I understand that refills of my child's medication will be made only at the times of office visits, or during regular office hours if I call 5 business days ahead of time with a refill request. I understand that after I have called for a refill request, I should call the office the day I plan to pick it up to be sure that the physician has had the opportunity to write the prescription. I understand that refills are NOT available after office hours, on weekends, or through an on-call physician.

I understand that I may be asked for photo ID when picking up my child's prescription. I understand that I may leave written permission for some other adult designee (over age 18) to pick up my child's prescription and that the designee may be asked to provide photo ID when picking up my child's prescription.

I understand that my child is required to see the healthcare provider in a face-to-face appointment at least _____ times each year.

**I understand that any provisions not followed in this Agreement could be grounds for discharge from care.**

I agree to follow the guidelines that have been fully explained to me. All of my questions and concerns regarding these medicines have been adequately answered. A copy of this Agreement has been given to me.

This Agreement is entered into on this _____ day of _____, _____.

Patient: _____ Provider: _____

Parent/Guardian: _____ Relationship: _____

Witness: _____

PARENT CONTROLLED MEDICINES AGREEMENT

Patient Name

Date of Birth