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 provider in complying with the law regarding controlled medicines.

TERMS OF AGREEMENT:

I understand that my child's provider 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 provider/patient relationship. I understand that if I break this Agreement, my child's provider 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 provider 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 legal or illegal controlled substances, including marijuana (recreational or medicinal), cocaine, alcohol, and prescription drugs not prescribed by my child's provider. I agree that my child will submit to random drug screenings and random pill counts if requested by my child's provider to determine compliance with my child's program of controlled medication management.

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 provider prescribed it and make no changes to the dose, nor discontinue the medication, without instruction from my child's provider.

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

I agree to use _____ pharmacy, located at _____, for filing prescriptions for all 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 provider may not replace lost, misplaced, or stolen medicines. If I have trouble with safeguarding my child's medicine, I understand my child's provider will discuss this with me and may elect to remove my child from therapy with controlled medicines.

I agree that refills of my child's prescriptions for controlled medicines will be made only at the time of an office visit or during regular office hours because an evaluation of my child's circumstances or condition must be made. No refills will be available outside of normal business hours.

I understand that I may be asked for a valid 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 a valid 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.

Patient Name:

Date of Birth:

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I understand that any provisions not followed in this Agreement is considered non-compliance with this Agreement and may be grounds for dismissal from care.

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

All controlled substances carry the risk of addiction

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

Patient: _____ Provider: _____

Parent/Guardian: _____ Relationship: _____

Witness: _____

Patient Name:

Date of Birth: