ADD/ADHD

CONTRACT

Cardinal Pediatrics
304-599-8000

Quick Info

We want to make sure our caregivers understand that the medication of a child is a serious step and one not taken lightly. We want to ensure agreement and understanding. We are here to help your child and always have the best interest of your child. We are a team.

Contract

- I agree to have Cardinal Pediatrics write the medication for managing my child's ADHD. I will obtain all my prescriptions for this medication from one pharmacy. The exception would be an emergency situation or in the unlikely event that I run out of medication. Should such an occasion occur, I will inform my physician as soon as possible and allow for a minimum of a 5 day notice period prior to when a refill is needed. I understand that I should stay with the same provider at Cardinal Pediatrics for all appointments.
- I understand the importance of giving the medication at the dose and frequency prescribed by my child's physician. I will give the medication as prescribed. I understand that expected prescription refill dates will be used to promote optimal use of this medication.
- Random urine testing from my child is a matter of routine monitoring and should be expected.
- My child and I will attend all reasonable appointments, treatments and consultations as requested by my child's physician. Medical appointments for my child's medication management will occur every 30 days until medication is stable and then every 90 days.
- I understand that I should check with my child's physician or pharmacist before giving my child other medications including over the counter medications and herbal products.
- I agree to be responsible for the secure storage of my child's medication at all times. I agree not to sell or give my prescribed medication to any other person. I acknowledge that my child's physician is not obligated to replace any medication shortfall.
- I consent to open communication between my physician and any other health care professionals involved in my child's adhd management, such as pharmacists, other doctors, and emergency departments.
- I understand that if I break this agreement my child's physician reserves the right to stop prescribing stimulant medications for my child.
- I agree to seek scholastic progress reports from my child's teachers twice per year and inform physician

Patient

- Name
- Date of Birth

Caregiver

- Signature

- Name
- Date

304-599-8000

Remember we are only a phone call/text away!