

**The George Washington University Student Health Center (GWU SHC)
Psycho-stimulant Medication Agreement**

When appropriately prescribed, stimulants are generally safe when used as directed. I agree to use the stimulant medications only in the manner and at the dose prescribed to me.

I understand these medications are **controlled substances** and are tightly regulated by state and federal law because of a high risk for abuse.

I understand that it is a **FELONY** to obtain these medications by fraudulent means, to possess these medications without a legitimate prescription, and to give or sell these medications to others for *any* reason.

I acknowledge that violation of the policies concerning controlled substances will result in termination of my prescription. I understand that my clinician and my pharmacy will cooperate fully with any city, state, or federal law enforcement or regulatory agency in the event of any possible misuse, sale, or other diversion of my medication or alteration of my prescription. Consequences for violating these policies also may include investigation by the Office of Student Rights and Responsibilities.

GWU SHC has a **one-time replacement policy**. I understand that if a stimulant medication is misplaced or stolen, the prescription will not be renewed unless I provide a crime report from George Washington University Police Department or other applicable law enforcement agency. After the first time a medication is lost, stolen, or damaged, the prescription will not be renewed before the 25-day renewal period. I acknowledge that I am responsible for protecting my medications from being lost or misused by other persons. I acknowledge that it is both illegal and potentially very dangerous to share with or sell prescription medications to another person. GWU SHS recommends that medications be locked in a personal safe and not placed in medication cabinets.

I acknowledge that my clinician may require a drug screening test before they provide a new prescription for the psycho-stimulant medication and I pledge to be cooperative with this screening. While this screening is voluntary and confidential, refusal may result in loss of ADHD prescription privileges. I understand that I am responsible for fees associated with obtaining a drug screen.

I agree to refrain from using any non-prescribed psychotropic medications or illegal substances while under treatment at GWU SHC. If there is any question of inappropriate drug use, my doctor may refer me for assessment and treatment for addictive disorders. Failure to follow through with these referrals will be considered a violation of this agreement and may result in loss of ADHD prescription privileges.

Prescription renewal will be provided only during a scheduled appointment and not on a walk-in basis. Appointments should be scheduled at least 3 days in advance. Missing appointments may result in the loss of ADHD prescription privileges.

I will communicate fully and on a timely basis with my clinician about the intensity of my symptoms, their effects on my daily life, the effectiveness of the medication in relieving my symptoms, and any significant side effects that occur. This includes keeping scheduled appointments with my designated clinician. If I am unable to tolerate any controlled medication or it is ineffective, I may be asked to bring in any unused medication to my clinician for proper disposal.

I understand that if I break this agreement, my clinician will stop prescribing the medication(s). I also understand that a drug dependence treatment program may be recommended. I agree to follow these guidelines.

Print Name _____ GWID# _____

Student's Signature _____ Date _____