PARENT/CHILD Medication Agreement for Long Term Controlled Substance Prescriptions in Children under 18 years of age

This is an agreement between _____ and _____.
My child, _____ is being treated with controlled substance medication for _____, which I understand may be abused or cause addiction and is only one part of the treatment. I understand that, because this medication has risks and side effects, my clinician needs to monitor my child's treatment closely in order to keep him/her safe. I acknowledge his/her treatment plan may change over time to meet his/her goals, and that his/her clinician will discuss the risks of my child's medicine, the dose, and frequency of the medication, as well as any changes that occur during his/her treatment. In addition, I agree to the following statements:

Parent Initials	**Please read the statements below and initial in the box at the left.**
	I understand that the medication may be stopped or changed to an alternative therapy if it does not help my child meet his/her goals.
	To reduce risk, I will ensure he/she takes the medication as prescribed. He/She will not take more pills or take them more frequently than prescribed.
	I will inform my child's clinician of all side effects he/she experiences.
	To reduce risk, I will ensure my child does not take narcotics, sedatives, alcohol, marijuana/cannabinoid products or illegal drugs while taking this medication.
	My child will submit to urine and/or blood tests to assist in monitoring his/her treatment.
	I will bring my child's pill bottles with any remaining pills of this medicine for a pill count when requested by Mountain View Family Practice.
	I understand that my child's clinician or his/her staff may check the state prescription drug database to prevent against overlapping prescriptions.
	I will receive my child's prescription for this medication only from Mountain View Family Practice clinicians. Refills will be made only during regular office hours. No refills will be provided on nights, holidays or weekends.
	I will fill my child's prescription at only one pharmacy. (Fill in pharmacy information below.)
	I will keep my child's medication in a safe place. I understand if my child's medicine is lost, damaged, or stolen, it will not be replaced.
	I will do my best to keep all of my child's scheduled follow-up appointments (at least every 3 months unless otherwise specified). I understand that I may not receive a prescription refill if my child misses his/her appointment.

Medication name, dose, frequency:

_____

Pharmacy name/location:

_____

By signing below, we agree that we are comfortable with this agreement and our responsibilities:
Parent/Guardian:_____ Date: _____
Physician/NP: _____ Date: _____