PSYCHOSTIMULANT MEDICATION CONTRACT

1. I have been prescribed psychostimulant medication for my treatment of ADHD or other condition.
2. I understand these medications are controlled substances and are tightly regulated by state and federal law with a high risk for abuse; therefore, the prescription must be written and can be for only a one month’s supply.
3. I understand that it is a FELONY to obtain these psychostimulant medications by fraudulent means, to possess these medications without a legitimate prescription, and to give or sell these medications to others. I acknowledge that it is both illegal and potentially very dangerous to share or sell prescription medication with another person.
4. I will not seek to have duplicate prescriptions written for me of the same medication. UND Student Health Services reserves the right to query and verify the quantity and frequency of prescription drug fills via the Board of Pharmacy.
5. I acknowledge that I am responsible for protecting my written prescription and my medication from being lost or misused by other persons. If a prescription is lost, stolen, or damaged or the medication itself is misplaced, the prescription will not be rewritten before a 25 day renewal period.
6. Prescription renewals will be provided only during a scheduled appointment and not on a walk-in basis.
7. I agree to be seen by a SHS provider monthly/per provider discretion for ongoing evaluation and prescription refills.
8. Information between UND SHS and my hometown provider may be shared for continuity of care regarding diagnosis and medication history as per signed Release of Information.
9. I acknowledge that violation or refusal to sign Psychostimulant Contract of said controlled substances could result in termination of my prescription privileges for those substances.

☐ I have read, understand, and agree to the conditions stated above.
☐ Patient refuses to sign Psychostimulant Contract

Witness: ___________________________ Date: ______________
Patient Signature_________________________ Date__________________________
Witness Signature ____________________________ Date__________________________
(nursing staff or medical providers)

*Contract Good for One Year*

*Form scanned into EHR: Scanned Documents

Original – Medical Record Yellow - Patient