Ascension Wisconsin *
Pediatric Controlled Substance Treatment Agreement

Your child has been prescribed a controlled substance medication to be used for certain conditions such as ADHD, sleep disorders, or pain disorders. Controlled substances are safest when used as directed. They also can cause serious harm if not used as prescribed. In addition, they are highly controlled by state and federal law. For your child’s safety, you need to understand your responsibilities and our policies regarding the use of controlled substances.

- Your child’s prescribing provider is ____________________________ (print provider’s name).

- Children on controlled substances are required to have periodic follow-up appointments with the provider. Parents and teachers may be asked to complete progress reports to evaluate the child’s progress. If a child does not return for follow-up appointments, the medication will be stopped until the child has been seen.

- At least one parent or legal guardian must attend follow-up visits for medication management.

- You are expected to give your child their medications exactly as prescribed and to supervise older children taking medications.

- If your child needs to take the medication at school, a medication permission form will need to be signed every year. For safety reasons, children should not be allowed to deliver the medication to school themselves.

- You may be asked to sign an annual consent to allow us to communicate with your child’s teacher or other school staff as needed.

- Your child needs to understand the danger of someone taking any medication that is not prescribed for them. Take the time to discuss these issues with your child.

- It is a FELONY to obtain controlled substances by dishonest means, to have these medications without a valid prescription, and to give or sell these medications to others. You cannot share your child’s medications with others.

- If there is evidence of misuse of your child’s medication, no further prescriptions will be issued. Your child may also be removed from the practice.

- Keep the medicine in a secure place such as a locked box to prevent theft. If medications are misplaced, stolen, or destroyed they will not be replaced.
• Refill requests can only be made during regular office hours, Monday through Friday. Call for a refill at least 3 business days in advance to avoid running out of medicine. Federal law states that the prescription cannot be filled any sooner than 7 days before the previous prescription would finish.

• We expect the prescription to be picked up by a parent or legal guardian. However, if this is not feasible, then we will require hand-written note providing permission or verbal consent over the phone. All persons picking up the prescription will be required to show a photo ID and sign for the medication.

• If you are requesting an early prescription because pills are stolen, then you must file a police report and provide us with the report number. The provider will then decide if a new prescription can be written early.

• When picking up the prescription please confirm that the name, date, medication, and dosage are written correctly and the physician signature is present.

• Controlled substance prescriptions must be filled within 7 days from the date it is written. If expired must bring prescription back to Pediatrics before requesting a refill.

• You may be asked to bring all of your child’s prescribed medications to their appointment in their original bottle.

• Your child may be asked to provide a urine sample to check medication levels. You may be asked to bring your child into the office for a random urine drug test or pill count.

• You must obtain controlled substance medications only from your child’s provider (or associate in the event of provider absence). We are obligated to check the state’s website to monitor this.

• Medications are only one part of your child’s treatment. Behavioral interventions may be used as part of a complete treatment program.

• Additional recommendations: ____________________________________________________________

By signing below, I acknowledge that I have received, read and understand these guidelines and agree to follow them.

Print Patient Name: ________________________________

Date: ______________________    Patient Signature: ________________________________

Date: ______________________    Parent Signature: ________________________________

Date: ______________________    Witness Signature: ________________________________

Date: ______________________    Physician Signature: ________________________________

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