

**BUCKNELL UNIVERSITY STUDENT HEALTH SERVICE  
PSYCHOSTIMULANT MEDICATION CONTRACT**

I have been prescribed psychostimulant medication for treatment of ADD or ADHD.

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 only be written for a one month supply.

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 am required to provide a letter from the health care professional who has been following me prior to college or sign a release so a letter can be requested. The letter should include a detailed summary of testing, previous care, and current prescribed medications.

I agree that my original prescribing physician will be notified, by receiving a copy of this contract, that my prescriptions are now going to be written by a physician of Bucknell University Student Health Service. I also agree that my original prescribing physician may disclose to Bucknell Student Health Service when prescriptions have been written for me in his or her office. I will not seek to have duplicate prescriptions of the same medication written for me.

If a prescription is lost, stolen, or damaged, or the medication itself is misplaced, the prescription will not be rewritten unless one has a crime report from either Bucknell University Public Safety or Lewisburg or East Buffalo Police Department. I acknowledge that I am responsible for protecting my written prescription and my medication from being lost or misused by other persons. I acknowledge that it is both illegal and potentially very dangerous to share or sell prescription medication with another person.

My clinician requires medication follow-up visits every month. Prescription renewal will be provided only during regular office hours, Monday through Friday.

The following items are required.

- Appropriate records regarding my diagnosis and need for medication on file.
- If I am referred to Psychological Services I agree to keep the appointment.

I agree to refrain from using any non-prescribed psychotropic medications or illegal substances while under treatment for ADD.

My clinician may require urine drug screening if concerns regarding substance abuse arise. I pledge to cooperate with this screening.

I acknowledge that violation of SHS policies concerning controlled substances will result in termination of my prescription for these substances.

I have read and understood this contract and I agree to fulfill my obligations.

Print Name \_\_\_\_\_ BUID# \_\_\_\_\_

Signature \_\_\_\_\_ Date \_\_\_\_\_

Witness \_\_\_\_\_ Date \_\_\_\_\_