**Concord Children's Clinic**

1040 Vinehaven Drive
Concord NC 28025

# PARENT CONSENT FORM FOR ADD/ADHD APPOINTMENTS

I……. (Parent/guardian)

of ……...(name of the patient) agree to the ADD/ADHD treatment plan that the physicians at Concord Children's Clinic have recommended for my child. This treatment plan requires that I must do my part to insure that my child is taking his/her medication as prescribed. Also, I agree to the following guidelines:

- I will bring my child for a follow up appointment within the month after starting the medication before it runs out. Follow up appointment needs to be scheduled at the time of initial appointment. _____
- I will make a follow up appointment with the physician every 3-4 months to get further refills for my child's ADD medication. It will be necessary to call a month in advance to schedule the appointment. _____
- I will give the physician <u>at least 3 business days</u> to refill my child's prescription. This prescription can be picked up in the office. A photo id of the person picking the prescription must be presented at the time of the pickup. Prescriptions can be mailed to the home address if I provide the clinic with self addressed, stamped envelope. _____
- A well child physical is required once a year. _____
- I will make certain that the Vanderbilt teacher follow up forms are completed and sent to the physician prior to each follow up appointment. _____

To insure that your child continues to get his/her medication it is important that you comply with these guidelines.

Date……..