STUDENT LIFE
UNIVERSITY HEALTH SERVICE
UNIVERSITY OF MICHIGAN

Place Label Here

Stimulant Medication Contract

I understand that stimulant medication has been prescribed for me. This contract is designed to help ensure its safe and effective use. I agree to the following:

1. The medication is prescribed for my use and my use only. I will not give, lend, or sell my medication to anyone else. Giving or selling the medication to someone else is considered a crime/felony.
2. The medication is to be stored in a safe and secure place, preferably locked and out-of-sight.
3. I will take the medication as prescribed. Any changes in dosing need to be discussed with the clinician who is prescribing my stimulant medication.
4. I will keep regular appointments with the clinician who is prescribing my stimulant medication. Missed appointments may result in cancellation of my stimulant prescription.
5. Lost/stolen medication will not be replaced.
6. I understand that using alcohol or taking illegal drugs while using a stimulant medication is dangerous.
7. I will abstain from the use of marijuana or other illicit drugs while taking stimulant medication. I understand that their use will jeopardize my continued prescription of stimulants.
8. I agree to random urine drug testing as requested by the clinician who is prescribing my stimulant medication. An unexpected result on the urine drug screen may lead to the cancellation of my stimulant prescription and may require treatment with a non-stimulant medication.
9. If asked, I will bring in my medication at any time, within reason, for a pill count to ensure that I am taking my medications as prescribed.
10. Stimulant prescriptions will not be provided through the triage clinic.

Misuse of stimulant medications is a common and recognized concern in this country. The University Health Service will not tolerate misuse of stimulant drugs. If you are concerned about your own prescription drug use or misuse, please contact UHS at 734-763-1320. I acknowledge that failure to follow these guidelines will lead to a break in this contract and may result in the discontinuation of my stimulant medication prescription.

I understand and will abide by this policy.

Patient Name (Print)	Prescriber Name (Print)
Patient Name (Signature) Date	Prescriber Name (Signature) Date