Name _____
DOB_____

**STIMULANT MEDICATION CONSENT FORM**

☐ **Adderall**

☐ **Methylphenidate**

☐ **Other stimulants**, Please specify: _____

Dr._____ would like to begin/continue this medication to help you with the following problems:

| |
|---|
| □Inattention |
| □Hyperactivity |
| □Impulsive behavior |
| □Disruptive behavior |

All medications have side effects. These side effects vary from person to person.
Here are some of the side effects you may feel:

**Common:**

| | |
|---|---|
| Loss of appetite | Headaches |
| Weight loss | Stomachache |
| Trouble falling asleep | |

**Rare:**

| |
|---|
| Changes in heart rhythm |
| Decreased growth |
| Mood changes, hallucinations, aggression |

**Very rare, but potentially life-threatening:**

| |
|---|
| Sudden death, heart attack and stroke |

**IF YOU EXPERIENCE ANY OF THESE SIDE EFFECTS OR ANY OTHER UNUSUAL FEELINGS, PLEASE TELEPHONE THE OFFICE AT _____. IF THE CONCERN IS SEVERE ENOUGH, PLEASE PROCEED TO AN EMERGENCY ROOM.**

We have reviewed the above medication and its possible side effects. We understand that we have the right to refuse medications, but agree to discuss this with our physician first. We also understand that if we have further questions regarding the above medication, we will discuss them with our physician.

_____
Parent/Legal Guardian Date

_____
Signature of Patient Date

_____
Prescribing Physician Date