

**PEDIATRIC ASSOCIATES OF BROCKTON
(508) 584-1234**

INFORMATION FOR PARENTS RE: ADD/ADHD TREATMENT
(STIMULANT CONSENT)

The medication I have selected for your child is _____.

- Side effects may include:
Decreased appetite (more common) Weight loss Headaches Dry mouth
Dizziness (usually disappears after several weeks) Insomnia Irritability
Drowsiness (less common) Increased blood pressure and heart rate
Constipation Abdominal pains and nausea
- Stimulants may also (very rarely) uncover a predisposition to tics and Tourette's Syndrome, especially in children who have a family history of these.
- There is no definite evidence that use of stimulants in children leads to dependency on it or any other drugs. However, it is very important to monitor the use of the drug on a regular basis.
- There is some controversy about how much growth suppression some stimulants may cause. There seems to be more of an effect on weight than height. It has been determined that long term stimulant use does not affect a patient's final height.
- **The black box warning on amphetamines notes two issues. One is the potential for abuse and diversion, and the other warns of potential for sudden death and serious cardiovascular effects if the drug is misused. Please note it is important for you or other family members to inform us promptly if there is a family history of heart rhythm problems or sudden cardiac death.**

I understand that a stimulant medication is being prescribed to my child to treat Attention Hyperactivity Disorder. I have been fully informed of the potential risks and benefits of such treatment. I understand that it is my responsibility to supervise the administration of such stimulant in the prescribed dosage, to report any side effects to the doctor in a timely manner and to bring my child into the office for follow-up appointments in 21 days, 4 months, 8 months and every six months there after, and for any lab work which my doctor may advise. I also understand that without these follow-up appointments the physician may not be able to prescribe the dosage effectively.

Childs Name _____ D.O.B. _____

Parent/Guardian Signature _____ Date _____

Physician Signature _____ Date _____