Illinois Mathematics and Science Academy

Psychotherapeutic Prescription Medication Contract

I am under a physician's care for a diagnosis of _____
_____
_____

An important component of my care is the psychotherapeutic prescription medication listed below:

Name of Medication Dose Frequency

1._____
2._____
3._____
4._____
5._____
6._____

I understand that IMSA supports my physician's treatment goals for me: improvement of health, enhancement of well-being, and promotion of optimal functioning. I agree to obtain my medication from the IMSA Student Health Care Services Office and take it as prescribed by my physician until I am released from treatment by my physician. I agree to communicate written orders from my physician to the health office staff regarding any change in medication, dosage, timing. I acknowledge that failure to follow my physician's treatment recommendations may jeopardize my continued enrollment at the Academy.

I have read, and I understand, the written contract provided. My questions have been answered to my satisfaction by IMSA Student Health Care Services Office personnel. I agree to be responsible for taking care of myself appropriately.

Date_____ Student's Signature_____

I have read, and I understand, the written contract provided. My questions have been answered to my satisfaction by IMSA Student Health Care Services Office personnel. I agree to be supportive of IMSA's policies regarding the administration of psychotherapeutic prescription medication to my child/ward.

Signature of Parent/Guardian_____
Date_____