

Dear Provider:

Please complete the form below that **will be required annually** if your patient participates in NCAA athletics and continues to require stimulant medications for their treatment. In completing this paper work, you acknowledge that you have reviewed the patient's health history and have informed them at some time of the safety information regarding stimulant use as well as misuse guidelines. Please attach any consult letters or notes that may clarify their diagnosis and the need to use stimulant medications for treatment.

Thank you for taking the time to do this. We greatly appreciate your assistance as we all try to comply with NCAA requirements!

Medical Exception ADHD / ADD

Date ____/____/ ____

Patient Name _____ Date of Birth ____/____/ ____

Your patient is a student athlete (SA) participating in intercollegiate athletics. The NCAA bans the use of some stimulant medications and requires that the following documentation be submitted to support a request for a medical exception in the case of a positive drug test for such use. For additional information, please visit the NCAA Health & Safety website <http://www.ncaa.org/wps/ncaa?ContentID=481>

Date of Clinical Evaluation: ____/____/ ____

Required ADHD evaluation components Comments:

Comprehensive clinical evaluation (using DSM-IV criteria) _____

Adult ADHD Rating Scale (e.g., Adult ADHD self-report scale (ASRS), CONNER's Adult ADHD reporting scale(CAARS)

Score: _____

Monitored blood pressure and pulse _____

Alternative non-banned medications have been considered _____

****please submit copies of test results for the SA's medical record & NCAA purposes****

Additional ADHD evaluation components

Reporting of ADHD symptoms by other significant individual(s); _____

Other Psychological testing; _____

Physical exam date: ____/____/____ Results: _____

Laboratory/testing; _____

Previous documentation of ADHD diagnosis: _____

Other/Comments: _____

Diagnosis: _____

Medication(s) and Dosage: _____

The student-athlete will follow-up with me in (circle one) 3 months, 6 months, 12 months, other _____

Physician Name (Printed): _____ Date: ____/____/____

Physician Signature: _____ Specialty: _____ (M.D. or D.O.)

Office Address: _____ Contact #: _____

Please feel free to attach any clinical SOAP notes that may help clarify your patient/ our athlete's diagnosis of ADHD/ADD and the need for stimulant medications. THANK YOU FOR YOUR TIME!

Student Athletes: Please complete the following;

I, _____, give _____ permission to release all information regarding my treatment for ADHD to the Bucknell University Athletic Department, and the National Collegiate Athletic Association. This authorization will be valid for one calendar year beginning on the date I sign this authorization. I may revoke this authorization at any time by submitting a letter in writing to the Director of Athletic Medicine or another member of the University Health Services, understanding that all information released prior to my revocation is excluded.

My typed name below indicates that I have read and understand the above statement.

Signature: _____

Date: _____

Parent/Guardian signature: _____

Date: _____ (if under 18 years)