



## Medical Exception ADHD / ADD

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Date of Clinical Evaluation: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name: \_\_\_\_\_

Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Provider: Your patient is a student athlete participating in intercollegiate athletics. The NCAA bans the use of some stimulant medications and requires that the following documentation is 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>

- Required ADHD/ADD evaluation components**      **Comments:** \_\_\_\_\_
- Comprehensive clinical evaluation (using DSM-IV criteria) \_\_\_\_\_
  - Adult ADHD/ADD Rating Scale (e.g., Adult ADHD/ADD self report scale (ASRS), CONNER's Adult ADHD/ADD reporting scale (CAARS) Score: \_\_\_\_\_
  - Monitored blood pressure<sup>1</sup> and pulse \_\_\_\_\_
  - Alternative non-banned medications have been considered \_\_\_\_\_

**\*\*please submit copies of test results for the athlete's college medical record/NCAA\*\***

### Additional ADHD/ADD evaluation components

Reporting of ADHD/ADD 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:** \_\_\_\_\_ (MD or DO)

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/ADD to Dr. Kenneth Barnes, Director of Sports Medicine and Head Athletic Team Physician and his representatives at Elon University Primary Care and Sports Medicine 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 Sports Medicine, understanding that all information released prior to my revocation is excluded. My signature below indicates that I have read and understand the above statement.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Parent/Guardian signature (if under 18 years): \_\_\_\_\_ Date: \_\_\_\_\_

