Medical Exception ADHD/ADD

Date ___ /___ /___

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 and 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 athlete's college medical records/NCAA

Additional ADHD evaluation components

Reporting of ADHD symptoms by other individual(s):_____
Other Psychological testing:_____
Physical exam Date: ___ /___ /____ Results: _____
Laboratory/testing: _____
Previous documentation of ADHD diagnosis: _____
Other comments:_____
Diagnosis:_____
Medications 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 to _____and the National College 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 College Health Services, 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: _____ Date:___ /___ /___ (If under 18 Years)