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 & 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 pressure1 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 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: ____

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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 #: ______________________________

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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 ,________________ 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 signature below indicates that I have read and understand the above statement.

Signature:____ Date: _____________

Parent/Guardian signature: _____________________Date:________________ (if under 18 years)