Saint Joseph's University
Sports Medicine Department
Medical Exception ADHD / ADD

Name _____ Date of Birth _____ Date _____

Provider: 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 pressure1 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 Saint Joseph's University Sports Medicine 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 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 of student-athlets:_____ Date: _____
(Parent/Guardian signature if under 18 years)