



BRIDGEWATER STATE UNIVERSITY
Athletics Department: Head Athletic Trainer
325 Plymouth Street
Bridgewater, MA 02739
Fax: 508-531-1447

NCAA MEDICAL EXCEPTION DOCUMENTATION: ADD/ADHD

Health Care provider: Your patient is a student-athlete participating in intercollegiate athletics at Bridgewater State university. The NCAA bans the use of some stimulant medications and requires that the following documentation be submitted, and kept in the student-athletes medical record, as preparation to support a request for a medical exception in the event that he/she tests positive for the banned substance. For additional information, please visit the ncaa health & safety website http://www.ncaa.org/wps/ncaa?ContentID=481.

Name of Student-athlete: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Authorization to Release

I, \_\_\_\_\_, give \_\_\_\_\_ permission to release all information regarding my diagnosis and treatment of ADD/ADHD to Bridgewater State University Athletic Training~Sports Medicine Department and the NCAA. This authorization is good for 1 calendar year from the date I sign the Authorization. My signature below indicates that I have read and understand the above statement.

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

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

Date of Diagnosis: \_\_\_\_/\_\_\_\_/\_\_\_\_

Required ADD/ADHD Evaluation Components Please check each of the following:

The student athlete has undergone:

- Yes No a Comprehensive clinical evaluation (using DSM-IV Criteria).
Yes No an Adult ADHD Rating Scale. Identify Scale: \_\_\_\_\_ Score: \_\_\_\_\_
Yes No Monitoring of Blood Pressure
Yes No Monitoring of Heart Rate.
Yes No Alternative non-banned medications have been considered.

Please identify other tests, evaluations or reporting used to make diagnosis:

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

Medication Prescribed: \_\_\_\_\_ Dosage: \_\_\_\_\_

The student-athlete will follow up with you in (circle one): 3 months 6 months 1 year Other: \_\_\_\_\_

Physician's Printed Name: \_\_\_\_\_ Specialty (if applicable): \_\_\_\_\_

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Physician's Address: \_\_\_\_\_ Fax: \_\_\_\_\_

\_\_\_\_\_ Phone: \_\_\_\_\_

Please submit copies of tests and any clinical notes that may help clarify your diagnosis of ADD/ADHD and the need for stimulant medication. These documents can be mailed to the address identified above or faxed to 508-531-1447. Attention: Head Athletic Trainer

THANK YOU FOR YOUR TIME!