Returning Athlete Packet

# MEDICAL PACKET

2015-2016

- ☐ Insurance Letter
- ☐ Student-Athlete Information Form
- ☐ Front & Back Insurance Card
- ☐ Medical History Form
- ☐ HIPAA Consent Form
- ☐ Drug Education Consent Form
- ☐ Concussion Education Consent
- ☐ Insurance Advocate Form
- ☐ ADHD Physician Information
- ☐ **NEW**/**Transfer** **Athletes** SICKLE CELL Test Results/ Policy

Current/Recent Injury within last calendar year:

- Send all medical information, PT notes, clinical exam notes, protocol for injury

Queens University of Charlotte

**TO**: Queens University of Charlotte Student-Athletes and Their Parents
**SUBJECT**: Athletic Physical and Insurance Requirements for the 2015-16 Academic Year

**Athletic Physical Information**

- **NEW ATHLETE**: All new/transfer student-athletes MUST complete their physicals with the Queens University of Charlotte Team Physicians prior to starting any participation in intercollegiate sports at Queens. NO outside physicals will be accepted for athletics.
- **RETURNING ATHLETE**: All returning athletes are required to complete an annual medical history update, prior to starting any participation in intercollegiate sports at Queens. If a returning athlete sustained an ongoing injury, or requires clearance from previous injuries. They too, will be seen by the Team Physicians prior to starting and participation in Queens athletics.

The final decision of physical disqualification(s) or reason for rejection is the responsibility of the team physician. Any additional testing (MRIs, EKGs, ECHOs, etc) deemed necessary by the team physician during your physical – **ARE THE SOLE FINANCIAL RESPONSIBILITY OF THE STUDENT-ATHLETE and/or STUDENT-ATHLETE'S FAMILY**.

**Athletics Insurance Coverage**

All Queens University of Charlotte student-athletes, athletic-training students, student-coaches, student-managers, and cheerleaders must provide evidence of primary insurance that includes coverage for athletic related injuries.

**NONE OF THOSE INDIVIDUALS LISTED ABOVE WILL BE ALLOWED TO PARTICIPATE UNTIL EVIDENCE OF CURRENT INSURANCE IS ON FILE WITH THE QUEENS UNIVERSITY OF CHARLOTTE ATHLETIC TRAINING DEPARTMENT.**

The NCAA's Catastrophic Injury Insurance Program covers student-athletes who are catastrophically injured while participating in a covered intercollegiate athletic activity (subject to all policy terms and conditions). This policy has a $90,000 deductible. This coverage does not qualify as the basic coverage required for athletics participation at Queens University of Charlotte. It is supplemental coverage in the event of a catastrophic injury. More information on this program can be found on the NCAA's website at www.ncaa.org.

All students are required to maintain adequate medical insurance during their enrollment at Queens University of Charlotte. If you wish to opt out of the student medical insurance plan, you must complete the online waiver form. Failure to do so will result in a delay in coverage or a charge for insurance you do not need. If you wish to waive the student medical insurance plan, please review your coverage. Note that, while it may be acceptable for a waiver, it may not provide the kind of security and coverage provided by our student plan, which is tailored to a Queens University of Charlotte student's specific needs.

**Insurance Verification Procedure:** For those athletes who are not covered under a primary insurance plan ***<u>YOU MUST</u>*** purchase the University insurance plan.

**United Healthcare Student Resource Plan**

All students are automatically enrolled into the plan. However keeping this plan is optional for those who currently have a primary insurance. ***All student-athletes with no form of primary insurance ARE REQUIRED TO PURCHASE THE UNITED HEALTHCARE INSURANCE PLAN***.

***IT IS YOUR RESPONSIBILITY TO DETERMINE COVERAGE IN THE STATE OF NORTH CAROLINA***. If your insurance only covers emergencies, it is important to recognize that this is not adequate insurance coverage for your student-athlete and will result in your student-athlete being required to see an ER physician prior to visiting any of our team physicians. If the primary family coverage is through an HMO, or out-of-state PPO, you must follow the proper procedures required by your plan. This is especially important if your plan requires pre-authorization to have your son/daughter treated out of your plan's service area. If these procedures are not followed properly, it may result in denial of excess coverage. Please be informed about how your insurance works!

**United Healthcare Student Resources Basic Health & Sickness plan**
Cost is $1526 and billed to students in two installments (one/semester). If you enroll in the program in the Fall, you CANNOT cancel it for the spring semester.

**Wavier Procedures**

- Go to: studentcenter.uhcsr.com (do not use www)
- Website is available for you to start opting out
- Final date to opt out is August 31 (for Fall 2015 semester)
- Print a copy of the waiver for your records

**Annual Athletics Fee for student-athletes**
Cost is $300 and this mandatory fee for all student-athletes is assessed in full to the student-athlete's account the first semester of enrollment for each academic year. The University is required to carry athletics insurance for its student-athletes. Due to the increase in healthcare charges, it has unfortunately become necessary to require student-athlete participation to offset the rising premium costs.

**For athletic-related injuries**

- **Category A: Student-athlete has primary insurance AND OPTS OUT of United Healthcare Student Resources plan):** Athletic-related injury occurs: Family insurance is primary. Bill is processed against primary insurance. If a balance remains it's processed against the University's athletic insurance policy. Should a balance remain after both insurances have paid, that balance becomes the student-athlete's responsibility
- **Category B: Student-athlete has primary insurance through parents AND is enrolled into United Healthcare Student Resources plan): At**hletic-related injury occurs: Family insurance is primary and bill is processed against this insurance first. If a balance remains, it's processed against the United Healthcare Student Resources plan (secondary). If a balance remains still, it's processed against the University's athletic insurance policy. Any final balance remaining after all insurances have paid, becomes the student-athlete's responsibility.
- **Category C: Student-athlete has NO PRIMARY insurance coverage and MUST KEEP United Healthcare Student Resources):** Athletic-related injury occurs: United Healthcare Student Resources is the primary insurance. Bill is processed against primary insurance. If a balance remains it's processed against the University's athletic insurance policy. Any final balance remaining after all insurances have paid, becomes the student-athlete's responsibility.

***If the student-athlete loses their primary insurance at any point during the academic year, he/she must purchase the University health insurance or acquire another primary health insurance policy immediately. If the student-athlete does not acquire new primary health insurance, he/she will be removed from athletic participation, the University, and will be responsible for any bills acquired due to injury/illness while participating in athletics.***

**Injury Management Procedure**
It is imperative that all injuries incurred while participating in intercollegiate athletics be dealt with through the Queens University of Charlotte Sports Medicine Staff. Failure to follow this procedure may result in unpaid insurance claims, which will then become the responsibility of the student-athlete. The Queens Sports Medicine staff will forward bills on to the Athletic Advocate at Hulse/QM for processing.

***I hereby authorize Queens Sports Medicine staff personnel and Hulse/QM Athletic Advocate to handle insurance claim processing on my behalf. This includes speaking directly to any medical provider about my injury claim bills.***

Any student-athlete who self-refers to an outside physician for any athletic-related injury risks not have their injury claim processed against the Queens University of Charlotte Secondary Athletic Insurance Plan. Accidents do occur and we attempt to provide our student-athletes with the best possible care. Medical bills may be incurred when a student-athlete is treated for bodily injury due to an accident, whether it is locally, during a road trip, or by a medical vendor in his/her hometown.

Unless the Team Doctor recommends otherwise, the Sports Medicine Staff will be responsible and utilized for treatment. All medical bills must be approved for payment by the Queens University of Charlotte Director of Sports Medicine in accordance with the Department of Athletics and NCAA policies.

**Injury Exclusion**: Jewelry and body ornaments, Queens University of Charlotte does not condone the wearing of any body ornaments or Jewelry during athletic participation. Body ornaments include but are not limited to, earlobe, nose, tongue, navel, eyebrow, nipple, etc. ***I acknowledge the aforementioned statements and policies, and accept any and all liability should I sustain an injury during athletic participation as the result of having any body ornaments or jewelry.***

I have read and understand Queens University's Intercollegiate Accident Insurance Policy and all policy relating to physicals and injury management. I agree to follow all procedures set forth in this document. I will also notify the Queens University of Charlotte Sports Medicine Department immediately if my primary insurance coverage changes, or I sustain an injury during competition in Queens University of Charlotte sanctioned sport activity.

Signature of Parent/Guardian___________________________________Date_______________

Signature of Student Athlete ____________________________________Date_______________

Print Athlete's Name___________________________________________Date_______________

# Parent/Guardian and Athlete Information Form

*Please **complete all blanks** on this form. A failure to do so may result in delays when processing claims. If information is not applicable, indicate why (i.e. deceased, divorced, etc.)

Full Name of Athlete________________________________________ Sport_______________________ Year: ____________

Student ID Number___________________________ Date of Birth ___________ Cell Phone____________________

College Dorm and Room Number_____________________________ Home Phone__________________________________________

Permanent Address_________________________________________ City____________________________ State_____ Zip________

Primary Care Physician______________________________________ Phone________________________________________________

Father/Guardian Information

Father's Name____________________________________

Social Security Number____________________________

Date of Birth______________________________________

Address__________________________________________

_________________________________________________

Employer_________________________________________

Address__________________________________________

_________________________________________________

Work Phone_______________________________________

Cell Phone________________________________________

EMAIL:______________________________

Medical Insurance (Only if the plan applies to the Athlete)

Company or Plan___________________________________

Address__________________________________________

Group #__________________________________________

Policy #__________________________________________

Telephone________________________________________

Is this plan an: ☐ HMO ☐ PPO ☐ Other

Is pre-authorization required to obtain treatment?

☐ Yes ☐ No

Is a second opinion required before surgery?

☐ Yes ☐ No

Is this plan: ☐ Primary ☐ Secondary

Mother/Guardian Information

Mother's Name____________________________________

Social Security Number____________________________

Date of Birth______________________________________

Address__________________________________________

_________________________________________________

Employer_________________________________________

Address__________________________________________

_________________________________________________

Work Phone_______________________________________

Cell Phone________________________________________

EMAIL:______________________________

Medical Insurance (Only if the plan applies to the Athlete)

Company or Plan___________________________________

Address__________________________________________

Group #__________________________________________

Policy #__________________________________________

Telephone________________________________________

Is this plan an: ☐ HMO ☐ PPO ☐ Other

Is pre-authorization required to obtain treatment?

☐ Yes ☐ No

Is a second opinion required before surgery?

☐ Yes ☐ No

Is this plan: ☐ Primary ☐ Secondary

Student-Athlete Signature____________________________________ ________________ Date________________

Parent/Guardian Signature (if athlete is a minor)________________________________________ Date________________

**ANNUAL HEALTH REVIEW**

**Note: All returning Student-Athletes must complete and return this form to be eligible to participate in intercollegiate athletics.**

Full Name (please print):_____________________________________________Sport_ _Date___________

Residence Hall/Apt. Address _____________________________________________. Cell phone#____________________________________

Student ID # __________________________________________Date of Birth_____________________

Home Address_________________________________________________________________Home Phone_____________________

Year in school (Check one)- ☐ Sophomore ☐ Junior ☐ Senior ☐ 5th

Please **Check** the correct response. If "**YES**" please explain (with dates) on the line to the right.

Since your **LAST** sports physical or "health status" review at Queens University of Charlotte have you:

| Question | Yes | No | Explain: (Diagnosis, Outcome,etc.) |
|---|---|---|---|
| Serious Injury or Hospitalizations in last year? | ☐ | ☐ | |
| Have you been knocked unconscious or have you ever suffered a concussion anytime this past year? | ☐ | ☐ | |
| In the past year have you had any injuries or illnesses? | ☐ | ☐ | |
| Have you seen a doctor for any medical problems in the last year? | ☐ | ☐ | |
| Are you currently under care of a physician or taking any kind of medication on a daily or regular basis? | ☐ | ☐ | |
| Do you, your parents, or physician at home believe that there should be any Limitations to full participation in your sport? | ☐ | ☐ | |
| Have you had any change in your vision in the past year? | ☐ | ☐ | |
| Do you wish to talk with a physician? | ☐ | ☐ | |
| Have you had any continuing problems from injuries suffered while in athletics at Queens University? | ☐ | ☐ | |

Treated for ADD/ADHD? ☐ Yes ☐ No

**MEDICATION LIST**

| **NAME** | **DOSAGE** | **REASON** | **COMMENTS** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Reviewed By ATC: _______________Date: ___________

## PRESCRIPTION MEDICATION AGREEMENT

*I agree to take the medication that was prescribed to me as directed by the physician and licensed pharmacist.*

*I further understand and agree that Queens University of Charlotte, its officers, employees, and agents are not responsible for any harm and possible permanent injury to my health caused by my present use of the medication that is prescribed to me. I agree to hold harmless, indemnify, and irrevocably and unconditionally release the state of North Carolina, the Queens University of Charlotte, and their officers, employees and agents from any and all liability, and demands, claims and causes of action relating to my use of the prescription medication.*

Student-Athlete Signature____________________________________________________________ Date________________

Signature of Parent/Guardian (if athlete is a minor)________________________________________ Date________________

## PERMISSION FOR MEDICAL RECORDS RELEASE/MEDICAL CONSENT

*I hereby authorize Queens University of Charlotte's Sport Medicine Staff and its insurance agent, to inspect or secure copies of the Queens University of Charlotte Health & Wellness Center's health record. I also consent for the release of medical records of past and future confinements and /or disabilities that may affect my ability to participate in intercollegiate athletic competition. A photo static copy of this authorization shall be deemed as effective and valid as the original. I hereby grant permission to the Queens University of Charlotte Team Physicians, and /or any consulting physician, to render any treatment or medical/surgical care that they deem reasonably necessary to my health and well-being. I also hereby authorize the Queens University of Charlotte Sports Medicine staff, operating under the direction and guidance of the Queens University University of Charlotte Team Physicians, to render me any emergency, first aid, preventative or rehabilitative treatment that they deem reasonably necessary to my health and well-being.*

Signature of Student Athlete for medical consent and records release _______________________________________ Date___________

Signature of Parent/Guardian (if athlete is a minor)_____________________________________________________ Date___________

## ACKNOWLEDGEMENT OF RISK AND INFORMED CONSENT/PRE-PARTICIPATION EXAM

I realize that participation in any sport can be a dangerous activity involving MANY RISKS OF INJURY. I understand there are risks including and not limited to death or paralysis, brain damage, cardiac arrest, serious injury to internal organs and to bones, joints, ligaments, muscles, tendons, and other serious injury or impairment to other aspects of my general health and well-being. I understand that the dangers and risks of participating in sports also include the potentially high cost of medical care and impairment of my future ability to earn a living, to engage in other business, social and recreational activities, and generally to enjoy life. Recognizing these risks, I choose to participate in the sport(s) of my choice at Queens University of Charlotte. I also understand that Queens University of Charlotte requires a pre-participation physical as a new athlete or annual health review for returning athletes each year for athletic participation. I will not knowingly participate if this exam is not completed and on file with the Sports Medicine Department. I am also responsible for contacting the Sports Medicine Department if I encounter any medical or orthopedic conditions that would alter or exempt my competitive status of a Queens University of Charlotte sponsored sport.

Student-Athlete Signature____________________________________________________________ Date________________

Signature of Parent/Guardian (if athlete is a minor)________________________________________ Date________________

**Student-Athlete Authorization/Consent**
**For Disclosure of Protected Health Information to**
**Queens University of Charlotte**

I, ________________________hereby authorize **Queens University of Charlotte** and its physicians, athletic trainers and health care personnel to disclose my protected health information and any related information regarding any injury or illness (physical/mental) during my training and participation in intercollegiate athletics to the following individuals:

- Athletic Training Staff
- Counseling Center
- Disability Services
- Residence Life
- Athletic Administration
- Parents/Legal Guardians
- Coaching Staff
- Professors/Advisors
- Outside Agencies (i.e. Insurance)
- Campus Health and Wellness Center
- Academic Support Services

I understand that my injury/illness information is protected by federal regulations under either the Health Information Portability and Accountability Act (HIPAA) or the Family Educational Rights and Privacy Act of 1974 (the Buckley Amendment) and may not be disclosed without either my authorization under the HIPAA or my consent under the Buckley Amendment. I understand that my signing of this authorization/consent is voluntary and that my institution will not condition or withhold any health care treatment or payment, enrollment in a health plan or receipt of any benefits (if applicable) on whether I provide the consent or authorization requested for this disclosure. I also understand that I am not required to sign this authorization/consent in order to be eligible for participation in NCAA athletics.

This authorization/consent expires 365 days from the date on my signature below, but I have the right to revoke it in writing at any time by sending written notification to the athletics director at Queens University of Charlotte. I understand that a revocation takes effect on its request date and does not affect any action taken to that date.

______________________________________________________________________
Printed Name of Student-Athlete Signature Date

________________________________ ___________________________________
Printed Name of Parent/Guardian (If Minor) Signature Date

**Queens University of Charlotte**
**Drug Education and Testing Program**
**Appendix B - Student-Athlete Consent Form**

I, ____________________________________, hereby acknowledge that I have received a copy of, read and been given the
(Name of Student-Athlete)
opportunity to ask questions regarding the Alcohol / Drug Education & Testing Program implemented for the Department of Intercollegiate Athletics at Queens University of Charlotte. I understand the policies, procedures and my responsibilities as described in such policy.

As a condition to my participation in intercollegiate athletics at Queens University of Charlotte, I consent to participate in the Alcohol / Drug Education & Testing Program. I understand that my participation in this program includes the collection and testing of my urine at various times during the academic year for drugs, alcohol, and/or other banned substances. I, the undersigned, understand that my negative drug testing samples may be used for further research by the NCAA.

I further consent to the release of the results of any drug test to the Director of Athletics or his/her designee, Assistant Director of Athletics for Compliance, my Head Coach, the Director of Sports Medicine and/or Associate/Assistant Athletic Trainers, Oversight (Appeals) Committee, and/or my parent(s) or guardian(s). I acknowledge and understand that a copy of this consent form may be sent to my parent(s) or guardian(s) along with a copy of the Alcohol / Drug Education & Testing Program. To the extent set forth in this document, I waive any privilege I may have in connection with such information.

I fully understand that the Queens University of Charlotte Alcohol / Drug Education & Testing Program is separate and distinct from the NCAA drug testing program and its sanctions, however, I also understand that sanctions may be imposed by Queens University of Charlotte under its Alcohol / Drug Education & Testing Program upon a positive result under the NCAA drug testing program.

Queens University of Charlotte, its officers, employees, and agents are hereby released from legal responsibility and/or liability for the release of any information and/or record as authorized by this consent form. I fully and forever release and discharge the aforementioned parties from any claims, demands, rights of action, or causes of action, present or future, whether the same be known or unknown, anticipated or unanticipated, resulting from my participation in Queens University of Charlotte's Alcohol / Drug Education & Testing Program including those claims, demands, rights of action, or causes of action arising out of any positive result under such Drug Education & Testing Program.

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| | |
|---|---|
| ______________________________ | ______________________________ |
| Student-Athlete Signature | Date |
| ______________________________ | ______________________________ |
| Printed Name of Student-Athlete | Date of Birth |
| ______________________________ | ______________________________ |
| Student ID# | Sport(s) |
| ______________________________ | ______________________________ |
| Parent/Guardian Signature (if a minor) | Date |

**Queens University of Charlotte**
**Student-Athlete Concussion Statement**

☐ I understand that it is my responsibility to report all injuries and illnesses to my athletic trainer and/or team physician.

☐ I have read and understand the *NCAA* ***Concussion Fact Sheet*** (http://ncaa.org/wps/wcm/connect/public/NCAA/Health+and+Safety/Concussion+homepage/Resources/). After reading the NCAA Concussion fact sheet, I am aware of the following information: ****Initial on line****

________ A concussion is a brain injury, which I am responsible for reporting to my team physician or athletic trainer.

________ A concussion can affect my ability to perform everyday activities, and affect reaction time, balance, sleep, and classroom performance.

________You cannot see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury.

________ If I suspect a teammate has a concussion, I am responsible for reporting the injury to my team physician or athletic trainer.

________ I will not return to play in a game or practice if I have received a blow to the head or body that results in concussion-related symptoms.

________ Following concussion the brain needs time to heal. You are much more likely to have a repeat concussion if you return to play before your symptoms resolve.

________In rare cases, repeat concussions can cause permanent brain damage, and even death.

_________________________________ ____________
Signature of Student-Athlete Date

_________________________________
Printed name of Student-Athlete

_________________________________
Parent/Guardian Signature (if minor)

*If you have any questions, please contact the Sports Medicine Staff at (704) 337-2405*

# AUTHORIZATION APPOINTMENT

I, ______________________________________________ do hereby appoint
Student Name

Hulse Associates, Inc./QM Services, Inc (Hulse/QM) as my personal representative to act on my behalf in matters of my health insurance, in particular the plan sponsored by ***Queens University of Charlotte.***

I understand this is a voluntary designation and that this designation gives the personal representative the same rights to my health insurance information as myself.

I further authorize Hulse/QM to communicate with any of my health providers, and to obtain billing and medical information needed to process my health insurance claim. I understand that communication of such information will be done frequently by electronic means.

I understand that it is not possible to grant access to some parts of my electronic medical record without also granting access to others.

I further authorize Hulse/QM to communicate with my parents on matters about my health insurance and insurance claims.

It is understood that this authorization agreement will expire 24 months from the date of my signature below. I understand that this authorization is revocable by me. Such revocation must be done by written notification to Hulse/QM by postal mail to the address shown below, or by fax to the fax number shown below.

However, any future revocation of this agreement remains in force regarding any past communications of my Personal Health Information.

**Please complete the following information**

***Student Information***

______________________________

Student Name – Please Print

______________

Date of Birth

______________________________

SIGNATURE

______________

Date of Signature

______________________________
______________________________
______________________________

Home Address

______________________________

Email Address

______________________________

Cell Phone #

***Personal Representative Information***

Allison Kunkel
Anne Kocsis
Dona Norris

Personal Representatives

Hulse Associates, Inc./QM Services Inc.

PO Box 2363
Mechanicsburg, PA 17055
800-273-1715
717-591-2093 Secure Fax

______________________________
______________________________
______________________________

School Address

## NCAA Banned Drugs and Medical Exceptions Policy Guidelines Regarding Medical Reporting for Student-Athletes with Attention Deficit Hyperactivity Disorder (ADHD) Taking Prescribed Stimulants

The NCAA bans classes of drugs because they can harm student-athletes and can create an unfair advantage in competition. Some legitimate medications contain NCAA banned substances, and student-athletes may need to use these medicines to support their academics and their general health. The NCAA has a procedure to review and approve legitimate use of medications that contain NCAA banned substances through a Medical Exceptions Procedure. The diagnosis of adult ADHD remains clinically based utilizing clinical interviews, symptom-rating scales, and subjective reporting from patients and others. The following guidelines will help institutions ensure adequate medical records are on file for student-athletes diagnosed with ADHD in order to request an exception in the event a student-athlete tests positive during NCAA Drug Testing..

**Student-Athlete Document Responsibility**. The student-athlete's documentation from the prescribing physician to the athletics departments/ sports medicine staff should contain a minimum of the following information to help ensure that ADHD has been diagnosed and is being managed appropriately (see Attachment for physician letter criteria):

a) Description of the evaluation process which identifies the assessment tools and procedures.
b) Statement of the Diagnosis, including when it was confirmed.
c) History of ADHD treatment (previous/ongoing).
d) Statement that a non-banned ADHD alternative has been considered if a stimulant is currently prescribed.
e. Statement regarding follow-up and monitoring visits.

**Institutional Document Responsibility**. The institution should note ADHD treatment in the student-athlete's medical record on file in the athletics department. In order to request a medical exception for ADHD stimulant medication use, it is important for the institution to have on file documentation that an evaluation has been conducted, the student-athlete is undergoing medical care for the condition, and the student-athlete is being treated appropriately. The institution should keep the following on confidential file:

a) Record of the student-athlete's evaluation.
b) Statement of the Diagnosis, including when it was confirmed.
c) History of ADHD treatment (previous/ongoing).
d) Copy of the most recent prescription (as documented by the prescribing physician).

**Requesting an NCAA Medical Exception**:

a) The student-athlete should report the banned medication to the institution upon matriculation or when treatment commences in order for the student-athlete to be eligible for a medical exception in the event of a positive drug test.
b) A student-athlete's medical records or physician's letter should not be sent to the NCAA, unless requested by the NCAA.
c) The use of the prescribed stimulant medication does not need to be reported at the time of NCAA drug testing.
d) Documentation should be submitted by the institution in the event a student-athlete tests positive for the banned stimulant. Note: The NCAA Committee on Competitive Safeguards and Medical Aspects of Sports may approve stimulant medication use for ADHD without a prior trial of a non-stimulant medication. Although the NCAA Medical Exception Policy requires that a non-banned medication be considered, the medical community has generally accepted that the non-stimulant medications may not be as effective in the treatment of ADHD for some in this age group.

**DISCLAIMER**: The National Collegiate Athletic Association shall not be liable or responsible, in any way, for any diagnosis or other evaluation made, or exam performed, in connection herewith, or for any subsequent action taken, in whole or in part, in reliance upon the accuracy or veracity of the information provided hereunder

**ADHD Physician Letter**

Name: __________________________ Date: _____________ 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. Criteria for letter from prescribing Physician to provide documentation to the Athletics Department/Sports Medicine staff regarding assessment of student-athletes taking prescribed stimulants for Attention Deficit Hyperactivity Disorder (ADHD), in support of an NCAA Medical Exception request for the use of a banned substance.

**The following must be included in supporting documentation**:

- ☐ Student-athlete name.
- ☐ Student-athlete date of birth.
- ☐ Date of clinical evaluation.
- ☐ Clinical evaluation components including:
  - a. Summary of comprehensive clinical evaluation (referencing DSM-IV criteria) – attach supporting documentation.
  - b. ADHD Rating Scale(s) (e.g., Connors, ASRS, CAARS) scores and report summary – attach supporting documentation.
  - c. Blood pressure and pulse readings and comments.
  - d. Note that alternative non-banned medications have been considered, and comments.
  - e. Diagnosis.
  - f. Medication(s) and dosage.
  - g. Follow-up orders.

**Additional ADHD evaluation components if available**:

- ☐ Report ADHD symptoms by other significant individual(s).
- ☐ Psychological testing results.
- ☐ Physical exam date and results.
- ☐ Laboratory/testing results.
- ☐ Summary of previous ADHD diagnosis.
- ☐ Other comments.

**Documentation from prescribing physician must also include the following**:

- ☐ Physician name (Printed)
- ☐ Office address and contact information.
- ☐ Specialty.
- ☐ Physician signature and date.

**Student Athletes: Please complete the following**:

I, ______________________________, give _____________________ permission to release all information regarding my treatment for ADHD to the Queens Sports Medicine Dept., and the National Collegiate Athletic Association. The 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.

Signature Student Athlete: __________________________ Date: _____________

Parent Signature of Student Athlete (under 18): _____________________ Date: ______________