CARTHAGE COLLEGE PRE-PARTICIPATION PHYSICAL EVALUATION

PYSICIAN SIGNATURE IS REQUIRED. NP, PA-C NEED MD OR DO SIGN OFF.

Name: _____ Date of Birth:_____

Sex: M F Age: _____ Sport(s): _____

Medications & Supplements:_____

Body Composition/General Information

Height: _____ Weight: _____ % Body fat: _____

Temperature: _____ ^{o}F Date of last tetanus booster: ____/____

Vision & Balance Screening

Vision Corrected: Y N PEARL: Y N Color blind: Y N

Peripheral Vision-WNL: Y N Rhomberg-WNL: Y N

Comments: _____

Cardiovascular & Sickle Cell Screening

Blood pressure: _____/_____ Pulse: _____ bpm

The NCAA and Carthage College now recommends all student-athletes who are unable to confirm their sickle cell trait status undergo sickle cell trait testing prior to participation in any intercollegiate activity.

Physicians should attach a sickle cell screen, hemoglobinopathy evaluation, or hemoglobin electrophoresis results to this physical. Athletes must show proof of being tested for sickle cell trait, as recommended by the NCAA.

Sickle Cell Trait: Y N Sickle Cell Trait Screen Date _____/_____

*****ATTACH SICKLE CELL SCREEN RESULTS*****

ATHLETE PARTICIPATION MAY BE RESTRICTED IF THIS SECTION IS NOT COMPLETED

Page 1 and 2 of this document must be presented to Physician

1. ENT o Normal o Abnormal
Comments: _____

_____

2. Neurological o Normal o Abnormal
Past history of head injuries/concussions reviewed: **o Neurologist clearance needed**

Comments: _____

_____

3. Cardiopulmonary o Normal o Abnormal
Comments: _____

_____

4. Abdomen o Normal o Abnormal
Comments: _____

_____

5. Orthopedic o Normal o Abnormal
Recent history of orthopedic injury/surgery: **o Orthopedic clearance needed**

Comments: _____

_____

6. Skin o Normal o Abnormal
Comments: _____

_____

7. Genitalia o Normal o Abnormal
Comments: _____

_____

MD/DO Clearance:
o Unlimited sports participation o Limited to specific sport: _____
o Deferred until: _____

If the student is not cleared list reason for disqualification: _____

*****PHYSICIAN SIGNATURE IS REQUIRED. NP, PA-C, NEED MD OR DO SIGN OFF*****

Physician Signature ***(MD/DO only)***: _____ Date: ____/____/____

Name (printed): _____ Phone #: _____

Address: _____

_____

Page 1 and 2 of this document must be presented to Physician

Carthage College Athletic Training – Sickle Cell Trait Testing

About Sickle Cell Trait:

- Sickle cell trait is an inherited condition of the oxygen-carrying protein, hemoglobin, in the red blood cells
- Sickle cell trait is a common condition (> three million Americans)
- Although sickle cell trait is most predominant in African-Americans and those of Mediterranean, Middle Eastern, Indian, Caribbean, and South and Central American ancestry, persons of all races and ancestry may test positive for sickle cell trait.
- Sickle cell trait has been associated with a condition known as exertional rhabdomyolysis, renal failure and death. Complicating factors include extreme exertion, increased heat, altitude and dehydration.
- Sickle cell trait is usually benign, but during intense, sustained exercise, hypoxia (lack of oxygen) in the muscles may cause sickling of red blood cells (red blood cells changing from a normal disc shape to a crescent or "sickle" shape), which can accumulate in the bloodstream and "logjam" blood vessels, leading to a collapse from the rapid breakdown of muscle starved of blood.

Sickle Cell trait Testing:

- The **NCAA** recommends that all NCAA Division III student-athletes have knowledge of their sickle cell trait status
- Carthage College recommends that all student-athletes who are unable to confirm their sickle cell trait status undergo sickle cell trait testing prior to participation in any intercollegiate athlete activity.
- **Sickle cell trait testing in the form of a blood test can be done by the student-athlete's personal primary care physician or by the United Hospital Kenosha Campus Laboratory. Testing generally costs between $25-75 depending on the testing site. THIS EXPENSE IS THE RESPONSIBILITY OF THE STUDENT-ATHLETE.**

Test Results or Sickle Cell Trait Testing Waiver

After reviewing the above information and the NCAA Fact Sheet for Student-Athletes I have elected to (please check and fill in):

☐ I will provide documented proof of my Sickle Cell Trait status from previous testing to the athletic training staff (as well as answer below):
Test Results (circle): Positive Negative

☐ I, _____ understand and acknowledge that the NCAA and Carthage College Department
(Student-Athlete Name)
of Athletics recommends that all student-athletes have knowledge of their sickle cell trait status. Additionally, I have read and fully understand the aforementioned facts about sickle cell trait testing.

Recognizing that my true physical condition is dependent upon an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries, ailments and/or disabilities experienced, I hereby affirm that I have fully disclosed in writing any prior medical history and/or knowledge of sickle cell trait status to the Carthage College Athletic Training Staff.

I do not wish to undergo sickle cell trait testing and I voluntarily agree to release, discharge, indemnify, and hold harmless Carthage College, its officers, employees, and agents from any and all costs, liabilities, expenses, claims demands, or causes of action on account of any loss or personal injury that might result from my non-compliance with the recommendation of the NCAA and the Carthage College Department of Athletics.

I have read and signed this document with full knowledge of its significance. I further state that I am at least 18 years of age and competent to sign this waiver.

Student-Athlete Signature _____ Date _____ School ID# _____

Parent/Guardian Signature (if under 18 years of age) _____ Date_____

Witness Signature _____ Print Name _____ Date _____

PLEASE ATTACH A COPY OF PRIMARY MEDICAL INSURANCE CARD

2013-2014

Front :

Back:

2013-2014 ATHLETE INSURANCE AND EMERGENCY INFORMATION

Athlete Name_____ Birth date ___/___ /____

Student ID #_____ Athlete's Cell # (_____)_____

Parent Names_____ Home # (_____)_____

Address_____

City_____State_____Zip_____

Family Physician_____ MD phone # (_____)_____

Emergency Contact Information

Contact Person_____ Relationship_____

Cell/Home # (_____)_____ Work # (_____)_____

	Primary Policy	**Secondary Policy**
Policy Holder:		
Birth date:	_____/_____/_____	_____/_____/_____
Employer:		
Employer Phone #:	(_____)_____	(_____)_____
Insurance Co:		
Insurance Address:		
City/St/Zip:		
Telephone #:		
Policy ID#:		
Group #:		
Effective date:	_____/_____/_____	____/_____/_____
Type of policy: (Circle one)	HMO PPO POS Medicaid (WI only)	HMO PPO POS Medicaid (WI only)

Policy Exclusions: Explain:_____ Explain:_____

- **The primary policy MUST cover intercollegiate athletics, applicable to coverage in Wisconsin, and retained for the length of the athletic participation.**
- **Submit a copy of the front and back of the current insurance card**

I give my permission to release information to the health provider in the event the student-athlete needs treatment off-campus.

Policy holder signature:_____ Date:_____/_____/____

CARTHAGE COLLEGE MEDICAL CONSENT AND MEDICAL INSURANCE AGREEMENT

Medical Consent Authorization

I hereby grant permission to the Carthage College Athletic Training Department Staff, Team Physicians and Consultants to render myself, and/or son/daughter, any treatment or medical care deemed reasonably necessary. This includes preventative care, first aid, diagnostic testing, rehabilitation, emergency treatment, and/or hospitalization.

_____	_____	_____, 2013
Printed Name of Student Athlete	Signature of Student Athlete	Date

---

Medical Insurance Agreement

Carthage College provides **excess athletic accident coverage** for all student-athletes participating in intercollegiate athletics. An accident is defined as an unexpected, sudden, and definable event which is the direct cause of bodily injury independent of any illness, prior injury, or congenital disposition. Coverage is NOT provided for medical expenses resulting from illness, disease, or conditions unrelated to accidental bodily injury. Pre-existing conditions, out-of-season injuries, injuries that occur in-season that are not directly related to competition or supervised or routine medical care are not covered***. Students must maintain primary insurance that covers intercollegiate athletics and is applicable to coverage in the state of Wisconsin.*** A copy of the insurance card (front and back) needs to be on file.

In the event an athletic claim is filed, the procedures listed below must be followed to ensure excess coverage through Carthage College.

- Carthage Athletic Trainer must perform initial evaluation and student-athlete must comply with treatment.
- All non-emergency injuries are to be treated on-site for 72 hrs before referral or second opinion.
- If a student-athlete is accidentally injured during competition or supervised practice and generated medical expenses associated with the accident, all claims must first be filed with their primary insurance company.
- If a balance remains after the personal insurance company has paid its maximum, that balance can be submitted to the school's insurance company. The student-athlete must submit the bill to the school nurse along with a copy of the EOB (explanation of benefits) from their insurance company showing that the personal insurance has already paid its maximum.
- If the expense is covered, the school's insurance company will pay the balance of the eligible medical expenses up to the maximum of the policy after the $500 deductible is met.
- If the primary coverage is through an HMO or PPO, the proper procedures required by that plan must be followed in order for the school's insurance to satisfactorily complete its portion of the claim.

I, the undersigned, understand the terms of this Medical Insurance Agreement.

_____	_____	_____, 2013
Printed Name of Student Athlete	Signature of Student Athlete	Date

_____	_____	_____, 2013
Printed Name of Parent/Guardian	Signature of Parent/Guardian	Date

2013-2014 CARTHAGE COLLEGE ATHLETIC MEDICAL HISTORY

Name:_____ Date of Birth:_____
Last First M.I.

Student ID#_____ Sport(s):_____ Yr in school: Fr So Jr Sr 5yr Cell Phone: (_____)_____

Parents or Guardian Name:_____ Home Phone: (_____)_____

Permanent Address:_____City:_____State:_____Zip:_____

Allergies:_____ *Current Medications:_____

Please answer all questions and be as complete as possible. Include all information relating to your current and past medical history.
Explain any "YES" answers in the space provided. R/L is meant to differentiate right and left sides. For all (*) conditions provide medication info above.

DISEASE & ILLNESS

*Asthma or Exertion Induced Bronchospasm	YES NO	*Heart Condition	YES NO	*Iron deficiency/Anemia	YES NO
*Attention Deficit Hyperactivity Disorder	YES NO	Heat Illness	YES NO	Infectious mononucleosis	YES NO
*Diabetes	YES NO	Hernia	YES NO	Rheumatic fever	YES NO
Eating Disorder/Disordered Eating	YES NO	Hepatitis	YES NO	Sickle Cell Trait	YES NO
*Epileptic seizures or convulsive disorders	YES NO	Hemophilia/bleeding issues	YES NO	Staph/MRSA	YES NO
Exertion syncope (fainting during exercise)	YES NO	Intense chest pain	YES NO	*Thyroid Disease/Condition	YES NO

Explanation of any YES responses (severity, year of occurrence, etc…)_____

_____

HEAD AND NECK INJURIES

Concussion or "knocked out"	YES NO	Cervical (neck) injury	YES NO	Spine or vertebral disc	YES NO
Multiple head injuries	#_____	"Stinger" or "burner" injury	YES NO	*History of headaches	YES NO
Season ending head injuries	YES NO	Injuries involving neurologist	YES NO		

Explanation of any YES responses (severity, year of occurrence, etc…)_____

_____

TORSO

Abdomen/Thoracic	YES NO	Ribs	YES NO	Lumbar/Sacrum Back	YES NO

Explanation of any YES responses (severity, year of occurrence, etc…)_____

UPPER EXREMITIES

Shoulder/Clavicle:	Fracture	YES (R/L) NO	Forearm	YES(R/L) NO
	Dislocation/Subluxation	YES (R/L) NO	Elbow	YES (R/L) NO
	Muscle Injury	YES (R/L) NO	Wrist	YES (R/L) NO
	Labrum	YES (R/L) NO	Finger	YES (R/L) NO
	Other	YES (R/L) NO	Surgeries to the upper extremity	YES (R/L) NO

Explanation of any YES responses (severity, year of occurrence, etc…)_____

_____

LOWER EXTREMITIES

Hip/Pelvis		YES (R/L) NO	Lower leg:	MTSS/Shin splints	YES (R/L) NO
Thigh:	Hamstring	YES (R/L) NO		Stress Fractures	YES (R/L) NO
	Quadriceps	YES (R/L) NO		Compartment Syndrome	YES (R/L) NO
	Other	YES (R/L) NO		Other	YES (R/L) NO
Knee:	Ligaments	YES (R/L) NO	Ankle:	Fracture	YES (R/L) NO
	Meniscus	YES (R/L) NO		Sprain/Strain	YES (R/L) NO
	Other	YES (R/L) NO	Foot		YES (R/L) NO
Patella		YES (R/L) NO	Toe		YES (R/L) NO

Explanation of any YES responses (severity, year of occurrence, etc…)_____

_____

EARS/EYES/DENTAL

Glasses	YES NO	Hearing aids	YES NO
Contact Lenses Hard_____ Soft_____	YES NO	Dental appliances	YES NO

GENERAL MEDICAL INFORMATION

Do you have an absence or loss of any organs?	YES NO	Organ:_____
Any change in current medications or allergies from previous year?	YES NO	Medication:_____
Has a physician ever limited/restricted you from athletic participation?	YES NO	
Any other health or medical related information not covered above?	YES NO	
Are you taking any ergogenic aids/vitamin supplements?	YES NO	Type/name:_____

Explanation of any YES responses (side of body, year of occurrence, etc…)_____

_____

FEMALE ATHLETES ONLY

Does your menstrual cycle occur on a regular basis? YES NO

CARTHAGE COLLEGE INTERCOLLEGIATE ATHLETIC PROGRAM
RELEASE AND WAIVER OF LIABILITY, ASSUMPTION OF RISK
AND INDEMNITY AGREEMENT

I, _____ ("Participant"), (or on behalf of my minor child) hereby acknowledge that Participant has voluntarily elected to participate in the Intercollegiate Athletic Program ("Program"), from August 1, 2013 – June 1, 2014. In consideration for being permitted by the Carthage College to participate in the Program, I hereby acknowledge and agree to the following:

ELECTIVE PARTICIPATION: I acknowledge that my participation is elective and voluntary.

RULES AND REQUIREMENTS: I agree to conduct myself in accordance with Carthage College policies and procedures, including their athletic department and athletic training department; and National Collegiate Athletic Association. I further agree to abide by all the rules and requirements of the Program. I acknowledge that Carthage College has the right to terminate my participation in the Program if it is determined that my conduct is detrimental to the best interests of the group, my conduct violates any rule of the Program, or for any other reason in Carthage College's discretion, except for those occurrences due to Carthage College's gross negligence or intentional acts.

INFORMED CONSENT: I have been informed of and I understand the various aspects of the Program. I understand that as a Participant in the Program, I will be engaged in activities that may include, but not limited to, practicing, training, observing, traveling to and from, and competing in Program events, during which I could sustain serious personal injuries, illness, property damage, or even death as a consequence of not only Carthage College's actions or inactions, but also the actions, inactions, negligence or fault of others, and that there may be other risks not known to me or not reasonably foreseeable at this time. I further understand and agree that any injury, illness, property damage, disability, or death that I may sustain by any means is my sole responsibility, except for those occurrences due to Carthage College's gross negligence or intentional acts.

RELEASE AND WAIVER OF LIABILITY: I, on behalf of myself, my personal representatives, heirs, executors, administrators, agents, and assigns, **HEREBY RELEASE, WAIVE, DISCHARGE, AND COVENANT NOT TO SUE** Carthage College, its governing board, directors, officers, employees, coaches, athletic trainers, agents, volunteers and any students (hereinafter referred to as "Releasees") for any and all liability, including any and all claims, demands, causes of action (known or unknown), suits, or judgments of any and every kind (including attorneys' fees), arising from any injury, property damage or death that I may suffer while playing, practicing or in any other way involved in my participation in the Program, **REGARDLESS OF WHETHER THE INJURY, DAMAGE OR DEATH IS CAUSED BY THE RELEASEES, UNLESS THE INJURY DAMAGE OR DEATH IS CAUSED BY THE RELEASEES' GROSS NEGLIGENCE OR INTENTIONAL ACTS, AND REGARDLESS**

OF WHETHER THE INJURY DAMAGE OR DEATH OCCURS WHILE IN, ON, UPON, OR IN TRANSIT TO OR FROM THE PREMISES WHERE THE ACTIVITY, OR ANY ADJUNCT TO THE ACTIVITY, OCCURS OR IS BEING CONDUCTED. I further agree that the Releasees are not in any way responsible for any injury or damage that I sustain as a result of my own negligent acts.

ASSUMPTION OF RISK: I understand that there are potential dangers incidental to my participation in Program activities, including but not limited to, practicing, training, observing, traveling to and from, and competing in Program events. I understand that there are potential dangers which may expose me to the risk of personal injuries, property damage, or even death. I am aware that the Program can involve vigorous activity involving severe cardio-vascular stress and/or violent physical contact. I understand that Intercollegiate Athletic activities involve certain risks, including but not limited to, death, serious neck and spinal injuries resulting in complete or partial paralysis, brain damages, and serious injury to virtually all bones, joints, muscles, and internal organs, and that protective equipment may be inadequate to prevent serious injury. I further understand that Intercollegiate Athletics involve a particularly high risk of knee, head, and neck injury. In addition, I understand that participation in the Program involves activities incidental thereto, including, but not limited to, travel to and from the site of the Program, participation at sites that may be remote from available medical assistance, and the possible reckless conduct of other participants. Furthermore, I understand that potential risks may arise due the following: travel to and from competitions and practices via private vehicle, common carrier, and/or Carthage College owned vehicle, weather conditions, facility conditions, equipment conditions, negligent first aid operations or procedures of Releasees, and other risks that are unknown at this time. **I KNOWINGLY AND VOLUNTARILY ASSUME ALL SUCH RISKS, BOTH KNOWN AND UNKNOWN, EVEN IF ARISING FROM THE ACTS IF THE RELEASEES**, **UNLESS THEY ARISE FROM THE RELEASEES' INTENTIONAL OR GROSSLY NEGLIGENT ACTS**, and assume full responsibility for my participation in the Program.

INDEMNITY: I, on behalf of myself, my personal representatives, heirs, executors, administrators, agents, and assigns, agree to hold harmless, defend and indemnify the Releasees from any and all liability, including any and all claims, demands, causes of action (known or unknown), suits, or judgments of any and every kind (including attorneys' fees), arising from any injury, property damage or death that I may suffer as a result of my participation in the Program, **REGARDLESS OF WHETHER THE INJURY, DAMAGE OR DEATH IS CAUSED BY THE RELEASEES OR OTHERWISE, UNLESS THE INJURY DAMAGE OR DEATH IS CAUSED BY THE RELEASEES' GROSS NEGLIGENCE OR INTENTIONAL ACTS.**

PERSONAL MEDICAL INSURANCE. I agree to purchase and maintain during the term of the Program personal medical insurance. I further acknowledge that I am responsible for the cost of any and all medical and health services I may require not directly related to my participation in the Program.

CERTIFICATION OF FITNESS TO PARTICIPATE: I attest that I am physically and mentally fit to participate in Intercollegiate Athletics and that I do not have any medical record of history that could be aggravated by my participation in my particular sport. Further I agree to

abide by Carthage College's requirements, rules and decisions for physicals and medical exams for student athletes.

MEDICAL CONSENT: I understand and agree that Releasees may not have medical personnel available at the location of the Program. In the event of any medical emergency, I authorize and consent to any x-ray examination, anesthetic, medical, dental or surgical diagnosis or treatment, and hospital care that Carthage College personnel deem necessary for my safety and protection. I understand and agree that Releasees assume no responsibility for any injury or damage which might arise out of or in connection with such authorized emergency medical treatment.

CHOICE OF LAW: I hereby agree that this Agreement shall be construed in accordance with the laws of the State of Wisconsin.

I understand that I may seek legal counsel of my own choosing to fully explain any terms of this Agreement to me before I sign it.

SEVERABILITY: If any term or provision of this Agreement shall be held illegal, unenforceable, or in conflict with any law governing this Agreement the validity of the remaining portions shall not be affected thereby.

I hereby acknowledge that I have read, understand and will abide by each of the terms and conditions of this Agreement.

Date: _____ _____

Signature

_____

Printed Name of Participant

Date:_____ _____

Printed Name of Witness

_____

Signature of Witness

Signature of Parent/Guardian for Participants Who Are Minors:

I certify that I have custody of Participant or am the legal guardian of Participant by court order. I HAVE READ THIS AGREEMENT AND FULLY UNDERSTAND AND AGREE TO ITS TERMS. **I AM AWARE THAT THIS AGREEMENT INCLUDES A RELEASE AND WAIVER OF LIABILITY, AN ASSUMPTION OF RISK, AND AN AGREEMENT TO INDEMNIFY Carthage College.** I agree to the foregoing conditions on behalf of my minor child.

Date: _____ _____

(Signature of Parent or Guardian)

_____

(Printed Name of Parent or Guardian)

Received by:

Date: _____ _____

(Signature)

_____

(Printed Name of Institution Official)

CCIW Injury and Illness Reporting
Acknowledgement Form

I, _____, acknowledge that I have to be an active participant in my own healthcare. As such, I have the direct responsibility for reporting all of my injuries and illnesses to the sports medicine staff of my institution (e.g., team physician, athletic training staff). I recognize that my true physical condition is dependent upon an accurate medical history and a full disclosure of any symptoms, complaints, prior injuries and/or disabilities experienced. I hereby affirm that I have fully disclosed in writing any prior medical conditions and will also disclose any future conditions to the sports medicine staff at my institution.

I further understand that there is a possibility that participation in my sport may result in a head injury and/or concussion. I have been provided with education on head injuries and understand the importance of immediately reporting symptoms of a head injury/concussion to my sports medicine staff.

By signing below, I acknowledge that my institution has provided me with specific educational materials on what a concussion is and given me an opportunity to ask questions about areas and issues that are not clear to me on this issue.

I, _____ have read the above and agree that the statements are accurate.
Student-athlete's name

_____ _____
Signature of student-athlete Date

_____ _____
Name of person obtaining consent Signature of person consenting

Student Athlete Authorization/Consent For Disclosure of Protected Health Information (PHI)

I, _____, hereby authorize Carthage College and its physician affiliates, athletic and other
(student athlete)
health care personnel to disclose my protected health information and any related information regarding any injury or illness during my training for and participation in intercollegiate athletics to the following:

Your initials below indicate your agreement to the release of your (PHI) in each category:

_____ *National Collegiate Athletic Association (NCAA) Datalys Injury Surveillance Tool*
I understand that my name will be removed and the records coded before being transmitted from my institution to the NCAA or Datalys and that neither the NCAA nor Datalys will identify me personally in any publication or disclosure of research results. Data will be stored on a secure server at Datalys Center in Grand Rapids, MI. I understand that my signing this portion of this authorization/consent is voluntary and that my institution will not condition 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 initial this portion of this authorization/consent in order to be eligible for participation in NCAA athletics.

_____ *My Personal Medical Insurance* For the use of electronic transmission, US post mail, or facsimile involving billing, reimbursement, benefits eligibility and plan-eligibility issues. **Authorization in this category is required to participate in athletics at Carthage College.**

_____ *The News Media* Should the media inquire as to the extent of an injury or illness, you are allowing Carthage College athletics representatives to discuss your condition.

_____ *Parents/Guardian* Should the parents/guardian inquire as to the extent of an injury or illness, you are allowing Carthage College athletics representatives to discuss your condition.

_____ I also allow any treating physicians or other medical facilities to disclose my medical records to the Carthage College Athletic Training staff for purposes of continued quality of care during my athletic participation at that institution. Fax to: 262-551-5809

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 (FERPA) of 1974 (the Buckley Amendment) and may not be disclosed without either my authorization under HIPAA or my consent under the Buckley Amendment.

This authorization/consent expires 380 days from the date of my signature below, but I have the right to revoke it in writing at any time by sending written notification to the athletic director at my institution. I understand that a revocation is not effective to the extent action has already been taken in reliance on this authorization/consent.

Printed Name of Student Athlete Signature Date

ATTENTION DEFICIT HYPERACTIVITY DISORDER TREATMENT GUIDELINES

Effective August 2009 stricter application of the NCAA Medical Exception policy for the use of banned stimulant medications to treat Attention Deficit Hyperactivity Disorder (ADHD) was enacted. This stricter application provides additional information to the Committee on Competitive Safeguards and Medical Aspects of Sports (CSMAS), which reviews requests for a medical exception to a positive drug test for these stimulant medications. This policy ensures that student-athletes are adequately monitored while using a stimulant medication and to verify that stimulants are not being used strictly for athletic performance enhancement. Any student-athlete who tests positive from the effective date will need to comply with this stricter application, even if that student-athlete had received an exception for the use of stimulant medication prior to August 2009.

This stricter application will require documentation that demonstrates the student-athlete has undergone a clinical assessment to diagnose ADHD, is being monitored routinely for the use of stimulant medication, and has a current prescription on file in order to be approved for a medical exception to the banned drug policy. This documentation will be kept on file at Carthage College and will be produced to the NCAA in the event the student-athlete tests positive for the banned medication. All HIPPA requirements will be met for the transmission of this medical information (NCAA Memo on Banned Stimulant Medication for ADHD 2/09).

If you are currently medicated for the treatment of ADHD your treating physician must complete the following:

Initial Compliance Documentation—See attached Attention Deficit Hyperactivity Disorder (ADHD) Medication Exemption Information form.

Annual Follow-up—Mandatory annual follow-up documentation. This requirement can be met by a letter from the prescribing physician, or a copy of the medical record, with written indication of the current treatment.

It is the responsibility of the student-athlete to ensure all documentation is on file with Carthage College prior to their athletic participation. Questions regarding this policy can be directed to Head Athletic Trainer, Jacob Dinauer at 262-939-6560.

CARTHAGE COLLEGE ATHLETIC TRAINING DEPARTMENT
ATTENTION DEFICIT HYPERACTIVITY DISORDER (ADHD)
MEDICATION EXEMPTION INFORMATION

Primary Care Physician/Health Care Provider
The student-athlete presenting this form to you plans to participate in intercollegiate athletics at our institution. Our institution is governed by the rules and regulations of the NCAA. New legislation beginning August 1, 2009, involves the collection of medical records for those student-athletes diagnosed/treated for ADHD/ADD utilizing specific medication which may be banned by the NCAA. In order to show compliance, we are asking our student-athletes to deliver this letter to their primary care physician/health care provider requesting completion and return in order to continue their NCAA participation while continuing the use of their ADHD/ADD medication. Please return this form and ALL necessary attachments to the student-athlete. Student-athletes may choose to give you permission to fax or mail the required documentation. See contact information. All student-athlete medical information will be kept confidential.

Carthage College Athletic Training
2001 Alford Park Drive
Kenosha, WI 53140
Phone 262-551-6107
Fax 262-551-5809

Examples of NCAA Banned-Drug Class
Stimulants: amphetamine, atomoxetine, dexmethylphenidate, dextroamphetamine, methamphetamine and methylphenidate. For more information please visit www.ncaa.org/health-safety.

Student-Athlete's Name: _____ **Date of Birth:** _____

Date of Initial Clinical Evaluation: _____ Date of most-recent follow up: _____

Blood Pressure / Pulse Reading and Comments: _____
_____

Physician's Diagnosis: _____

Medication (s) and Dosage Prescribed: _____

Follow-up Orders: _____
_____

Required Attachments:

1) A written summary of the comprehensive clinical evaluation (individual/family history, indication of mood disorders, substance abuse and previous history of ADHD treatment; incorporate DSM criteria to diagnose ADHD).

2) ADHD Rating Scales (ex: Connors, ASRS, CAARS) scores, report and supporting documentation.

3) A statement that a non-banned ADHD alternative has been **considered** if a stimulant is currently prescribed.

Printed Name of Physician: _____

Address: _____

Specialty: _____

Signature: _____ Date: _____