_____

Name Date of Birth SSN

_____

Primary Care Physician Address Phone Number

_____ is under my care for treatment of ADHD/ADD since _____
Patient's Name Date of initial treatment

YES NO Alternative non-stimulant medication use has been considered, or tried, with unsatisfactory clinical results

LIST those tried, if applicable_____
The current medication and dosage is: _____
Reason for this medication:_____
_____

YES NO The student-athlete has undergone formal psychological/neuropsychological testing confirming the diagnosis of ADHD or ADD.

Name and title of the provider who conducted the formal psychological evaluation:

_____

YES NO An accepted ADHD rating scale was used to make the diagnosis. If NO, how was the course of treatment determined? (Attach any clinical SOAP notes)

YES NO CONNER'S Adult ADHD reporting scales (CAARS)

YES NO ASRS (Adult ADHD self-report scale)

Other: _____

Please submit copies of test results for the athlete's college medical record/NCAA

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!

I, _____, give _____permission to release all information regarding my treatment for ADHD to 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 Head Athletic Trainer, with the understanding that all information released prior to my revocation is excluded.

My signature below indicates that [have read and understand the above statement.

Signature:_____ Date:_____

Parent/Guardian signature (if under 18 years) _____