

Hollins University
Attention Deficit Hyperactivity Disorder (ADHD) Medication Exemption Form

Primary Care Physician/Health Care Provider:

The student-athlete presenting this form to you plans to or already participates in intercollegiate athletics at our institution. Our institution is governed by the rules and regulations of the NCAA. New legislation that began 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 with this new legislation, we are asking our student-athletes to take this letter to their prescribing physician/health care provider to fill out and to provide the following information in order to continue/begin their NCAA participation while also continuing to take their ADHD/ADD medication. Please return this form to the student-athlete or to the following address or fax number:

Hollins University
Kelly Creasey, MS, ATC
Head Athletic Trainer
P.O. Box 9553
Roanoke, VA 24020
Phone (540) 362 -6205
Fax (540)362-6273 (Health and Counseling)

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

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

Date of initial evaluation: _____ Date of most-recent follow-up: _____

Blood Pressure: _____ Pulse: _____

Physician's Diagnosis: _____

Medication Prescribed/Follow-up Orders: _____

- ✓ Please attach a brief summary of the comprehensive clinical evaluations used to diagnose this student-athlete with ADHD/ADD (reference DSM-IV criteria) and any supporting documentation.
- ✓ Please attaché note-worthy alternative non-banned medications that have been tried or considered and why they were not utilized.
- ✓ Please attach any ADHD Rating Scale (ex: Connors, ASRS, CAARS) scores and report summaries

If available, please provide copies of the following:

- ADHD/ADD symptoms by other health care providers
- Any psychological testing results
- Any psychological testing results
- Laboratory/testing results helping to diagnose ADHD/ADD
- Previous ADHD/ADD diagnosis summaries not completed/diagnosed by the current physician

Name of Physician: _____

Address: _____

Specialty: _____

Signature: _____ Date: _____