Vanderbilt Sports Medicine

Medical Record Number

_____

For Office Use Only

Athlete Registration Form

All new & returning student-athletes must complete this form completely and return to the Athletic Training Room

Student-Athlete Information

Date: _____/_____/_____

_____ _____ _____ _____
Last Name First Name Middle Name Sport

☐ 5th year ☐ Senior ☐ Junior
☐ Sophomore ☐ Freshman
Eligibility

_____/_____/_____
Date of Birth

_____-_____-_____
Social Security Number

(_____)_____-_____
Cell Phone

☐ Female ☐ Male
Gender

_____ _____ _____ _____ _____
Primary Address City State Zip Code Country

_____ _____ (____)_____-_____
Family Physician First Name Family Physician Last Name Telephone Number

Primary Emergency Contact

_____ _____ ☐ Father ☐ Mother ☐ Self ☐ Other: _____.
Parent/Guardian First Name Parent/Guardian Last Name Relationship to Athlete

_____/_____/_____
Parent/Guardian Date of Birth

_____ _____ _____ _____ _____
Parent/Guardian Address City State Zip Code Country

(_____)_____-_____ (_____)_____-_____ (_____)_____-_____
Home Phone Cellular Phone Work Phone

_____
Email Address

Secondary Emergency Contact

[To be filled in by Certified Athletic Trainer]

_____ _____ (____)_____-_____
First Name Last Name Office Phone:

Parental Responsibility

By signing below, I acknowledge that I have read and understand *"The Policy on University and Parental Responsibility to Injured Athletes."* I acknowledge that I am responsible for having the correct and current insurance information filed with Vanderbilt Sports Medicine.

_____ _____/_____/_____
Parent/Guardian Signature Date

_____ _____/_____/_____
Student Athlete Signature Date

Vanderbilt Sports Medicine

Medical Record Number

_____

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_____
Student Athlete Full Name

Primary Insurance Information

_____ ____/____/_____ _____-_____-_____ ☐ Father ☐ Mother ☐ Self ☐: _____.
Name of Insured | Date of Birth | Social Security Number | Relationship to Athlete

_____ ____/____/_____ ☐ HMO ☐ PPO ☐ POS ☐ Other: _____.
Primary Insurance Company Name | Effective Date | Type

_____ _____ _____ _____ (_____)_____-_____
Primary Insurance Address | City | State | Zip Code | Phone

_____ _____ _____
Subscriber ID | Group/Policy Number | Plan Number

_____ _____ _____ _____ (_____)_____-_____
Employer Address | City | State | Zip Code | Phone

Attach copy of ***Primary insurance*** card (front side)	Attach copy of ***Primary insurance*** card (back side)

Prescription Insurance Information

_____ (_____)_____-_____
Prescription Insurance Company Name | Prescription Insurance Company Phone

_____ _____ _____
RxBin | RxPlan/RxPCN | RxGroup

_____ _____ _____
Issuer | ID | Name

Attach copy of ***Prescription insurance*** card (front side)	Attach copy of ***Prescription insurance*** card (back side)

Vanderbilt Sports Medicine

Medical Record Number

_____

For Office Use Only

_____
Student Athlete Full Name

Secondary Insurance Information

_____ Name of Insured

_____/_____/_____ Date of Birth

_____-_____-_____ Social Security Number

☐ Father ☐ Mother ☐ Self ☐: _____. Relationship to Athlete

_____ Secondary Insurance Company Name

_____/_____/_____ Effective Date

☐ HMO ☐ PPO ☐ POS ☐ Other: _____. Type

_____ Secondary Insurance Address

_____ City

_____ State

_____ Zip Code

(_____)_____-_____ Phone

_____ Subscriber ID

_____ Group/Policy Number

_____ Plan Number

_____ Employer Address

_____ City

_____ State

_____ Zip Code

(_____)_____-_____ Phone

Attach copy of ***Secondary insurance*** card (front side)	Attach copy of ***Secondary insurance*** card (back side)

Dental Insurance Information

_____ Dental Insurance Company Name

(_____)_____-_____ Dental Insurance Company Phone

_____ Subscriber ID

_____ Group Number

_____ Plan Number

Attach copy of ***Dental insurance*** card (front side)	Attach copy of ***Dental insurance*** card (back side)

Vanderbilt Athlete Travel Insurance Information and Emergency Contact

Date____-___-_____ Sport_____

Legal Name_____
Last First Middle

Date of birth____-___-_____ Cell Phone#(____) ____-_____ Home Phone#(____) ____-_____

Home address_____
Street Address/ Apt. # City State Zip

Primary Emergency Contact Information: (In the Event of Emergency 1st person we should try to contact.)
(If you are an international student you MUST provide a US Resident as a primary or secondary emergency contact.)

Name:_____ Relationship to Student:_____

□ Check if address is same as above

Address_____
Street City State Zip

Home phone#(____) ____-_____ Work phone#(____) ____-_____ Cell Phone#(____) ____-_____

Secondary Emergency Contact Information:

Name:_____ Relationship to Student:_____

Home phone#_____ Work phone#_____ Cell Phone#_____

Insurance Information

Primary Medical Health Insurance Information:

Insurance Name:_____ Plan Type: HMO □ PPO □ POS □ IND □

Claims Address:_____
Street City State Zip

Phone #(____) ____-_____

ID#_____ Group #_____

Effective Date: ____-___-____

Attach copy of Primary Insurance Card

(Front)

Attach copy of Primary Insurance Card

(Back)

Vanderbilt Sports Medicine

Policy on University and Parental Responsibility to the Injured Athlete

As part of Vanderbilt University's commitment to offering one of the premier athletic programs in the country, the Department of Athletics and Department of Sports Medicine aspires to provide the finest medical care to its athletes. It is important that you and your son/daughter understand the extent of our medical coverage and the procedures which must be followed in the event of an injury or illness. The medical care of all sport-related injuries or illnesses is coordinated through the Vanderbilt Athletic Training Room in the athletic department of Vanderbilt University.

Please note the following important points:

1. Vanderbilt University **requires that every student have health insurance**, family or individual, as part of his/her registration.

2. Your complete primary medical insurance information must be on file in the athletic training room. In fact, without this information on file, your son/daughter will not be allowed to practice or compete with the team. **Please complete the *Athlete Registration* form with *Parental Responsibility* signature and send it in the addressed envelope immediately. All student-athletes must complete the entire form each year.**

3. In the event of an **athletic** injury or illness, Vanderbilt's medical providers will bill your primary insurance directly from this information. **Please check with your current health insurance provider to insure coverage of your son/daughter while they are away at school.** You will need to check if there is out-of-state or out-of-network coverage available for non-emergent and/or emergent coverage. You may elect to purchase the Vanderbilt Student Insurance policy for additional coverage that your personal health insurance will not cover. You can review the school's policy and coverage at http://www.vanderbilt.edu/student_health/student-health-insurance

4. In the event that your medical coverage changes during the academic year, it is imperative you notify the athletic training room immediately. **Any bills incurred due to not registering insurance changes, will be the responsibility of the athlete and his/her family.**

5. Vanderbilt's financial responsibility is limited to those cases in which medical care is **authorized** or recommended by our training room staff or team physicians. Approved medical costs associated with the injury/illness, in excess of the athlete's primary insurance coverage, will be covered by Vanderbilt University; such as, deductible costs or rejected claims during the period the student is enrolled.

6. In the event a student suffers a disabling injury that prevents the student-athlete from continuing his/her academic pursuits, Vanderbilt University will provide disability payments for a time and amount specified in the current contract of insurance provided for this purpose by the University. The term disabling injury shall include coma, spinal injury resulting in paralysis, total or partial loss of use of an extremity, and brain injury or that definition for such injury as may be set forth in the contract of insurance provided for these purposes.

7. Every incoming student-athlete will have a physical examination by the Vanderbilt Team Physicians. If a pre-existing illness or injury is detected, the Athletic Department will not cover its cost of treatment.

8. All treatment of injuries must be authorized or administered by Vanderbilt University. **Any outside treatment obtained by an injured athlete without authorization will not create entitlement to reimbursement from Vanderbilt University.**

9. An athlete injured in events or competition not conducted or sanctioned by the Intercollegiate Department of Athletics of Vanderbilt University is not eligible for continued assistance. To help clarify the extent of athletic coverage in cases that are not obviously associated with practice and competition, please consider the following examples:

   Example A:
   Shoulder dislocation; off-season in weight room
   Decision: **Athletic Injury**

   Example B:
   Appendicitis at 8:00 p.m.; Emergency Room, hospitalization
   Decision: **Private Bill**

   Example C:
   Strep throat requiring antibiotic treatment; athlete is out of season
   Decision: **Student-Health Center** care included as part of student registration.
   Prescription medication costs are the responsibility of the athlete or his/her family.

   Example D:
   Tooth knocked out during athletic practice. Dental work required.
   Decision: **Athletic Injury**

We hope this information is helpful as you make plans for next year. Please feel free to call any of the phone numbers listed below if you have any questions. Injuries, illnesses and medical insurance policies and procedures can be complex. We look forward to working with your son/daughter and thank you for taking time to provide us with this medical information.

Important Phone Numbers:

Tom Bossung	Head Athletic Trainer 615-322-4119 (O)	tom.bossung@vanderbilt.edu
Mollie Malone	Asst Athletic Trainer 615-343-7762 (O) Insurance Coordinator 615-343-2592 (F)	mollie.malone@vanderbilt.edu

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Vanderbilt Varsity Athletics Pre-Participation Medical History

last four digits of social security number

Date

First Name | Middle Name | Last Name

Athlete Date of Birth | Athlete Social Sec Number | Primary Sport

Parent\Gaurdian Street Address

City | State | Zip Code | Country (if not USA)

Campus Telephone | Athlete's Cell Telephone

Academic Class (for upcoming year)

- ⬭ freshman
- ⬭ sophomore
- ⬭ junior
- ⬭ senior
- ⬭ 5th year

Gaurdian\Home Telephone | Work/Emergency Telephone

Legal Gaurdian First Name | Legal Gaurdian Last Name

Medical History

1. **How many years has it been since your last complete health examination, other than an exam that was required for you to participate in sports?**

   ⬭ **1 year** ⬭ **2 years** ⬭ **3 years** ⬭ **>3 years**

2. **Are you presently taking any prescribed or over the counter medication? (including birth control pills, insulin, allergy shots or pills, asthma inhalers, vitamin or mineral supplements, anti-inflammatories including aspirin, dietary supplements)**

   ⬭ **Yes (if so, please fill out the table below)** ⬭ **no**

Name of Medication	Dose	Frequency of Use
	mg	
	mg	
	mg	

2A. **Please list ALL supplements that you are currently taking or have taken in the last month. (this may include, but is not limited to: creatine phosphate, ephedrine, Red Bull, Rip Fuel, herbal products, PSO2, Spark, Cell Tech, HMB, weight-gainer products, etc.)**

3. **Do you have an allergy to any:**

			Specify
Drug or medicine (OTC or prescribed)	⬭ yes	⬭ no	
Foods	⬭ yes	⬭ no	
Insects or Animals	⬭ yes	⬭ no	
Plants, Grasses, Pollen, Dust	⬭ yes	⬭ no	
Other (list)	⬭ yes	⬭ no	

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4. Were you born with two normal:

			If no, specify abnormality:
Eyes	⬭ yes	⬭ no	
Ears	⬭ yes	⬭ no	
Kidneys	⬭ yes	⬭ no	

5. Has a doctor ever told you that you have had any of the following medical problems?

Mononucleosis	⬭ yes	⬭ no	Jaundice	⬭ yes	⬭ no
Rubella (German Measles)	⬭ yes	⬭ no	Stomach or Intestinal Ulcer	⬭ yes	⬭ no
Chicken Pox	⬭ yes	⬭ no	Hernia	⬭ yes	⬭ no
Repeated Sinus Infections	⬭ yes	⬭ no	Eczema	⬭ yes	⬭ no
Nose Fracture	⬭ yes	⬭ no	Psoriasis	⬭ yes	⬭ no
Hearing Defect or Loss	⬭ yes	⬭ no	Diabetes	⬭ yes	⬭ no
Recurrent Ear Infections	⬭ yes	⬭ no	Sickle Cell Anemia/carrier	⬭ yes	⬭ no
Epilepsy	⬭ yes	⬭ no	Other Anemia	⬭ yes	⬭ no
Tumor, Cyst, Growth or Cancer	⬭ yes	⬭ no	Abnormal Bleeding or Clotting Disorder	⬭ yes	⬭ no
Over/Under-Active Thyroid	⬭ yes	⬭ no			
Arthritis	⬭ yes	⬭ no	Leukemia/Blood Disorder	⬭ yes	⬭ no
Marfan's Syndrome	⬭ yes	⬭ no	Kidney Injury	⬭ yes	⬭ no
Oral Herpes (cold sore)	⬭ yes	⬭ no	Other Kidney Disease	⬭ yes	⬭ no
Genital Herpes, Chlamydia, etc.)	⬭ yes	⬭ no	Frequent Urinary Infections	⬭ yes	⬭ no
Injury to Liver or Spleen	⬭ yes	⬭ no	Depression/Anxiety	⬭ yes	⬭ no
Hepatitis	⬭ yes	⬭ no	Other Mental Disorder	⬭ yes	⬭ no
Tuberculosis	⬭ yes	⬭ no	Birth Defect	⬭ yes	⬭ no
Asthma	⬭ yes	⬭ no	Eating Disorder	⬭ yes	⬭ no
Exercise Induced Asthma	⬭ yes	⬭ no	Weight Loss > 10 lbs.	⬭ yes	⬭ no

6. Are you currently under the care of a physician or medical provider for any illness/condition? ⬭ yes ⬭ no

If yes, please explain

7. I am: ⬭ Over-Weight ⬭ Under-Weight ⬭ Ideal Weight

Specify your ideal weight:

Specify any special diet you follow

8. Do you regularly lose weight to participate in your sport? ⬭ yes ⬭ no

9. Have you ever felt forced to limit your food intake due to concerns about your weight and/or body size? ⬭ yes ⬭ no

10. Have you had a history of anorexia, bulemia and/or any other eating disorders? ⬭ yes ⬭ no

If yes, please explain

11. Would you like to meet with a dietitian to discuss your nutritional needs or eating habits? ⬭ yes ⬭ no

12. I use/used tobacco products: (check all that apply)

⬭ never used ⬭ smokeless tobacco ⬭ cigars ⬭ pipes ⬭ cigarettes ☐ packs/day

13. Do you presently have the following skin problems:

Rash	⬭ yes	⬭ no
Fungal Infections	⬭ yes	⬭ no
Cold Sore(s)	⬭ yes	⬭ no

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14. Have you ever had surgery of the following:

			Date	Reason for surgery
Eyes	⬭ yes	⬭ no	/ /	
Ears/Nose/Throat	⬭ yes	⬭ no	/ /	
Heart	⬭ yes	⬭ no	/ /	
Lungs	⬭ yes	⬭ no	/ /	
Stomach/Bowels/Appendix	⬭ yes	⬭ no	/ /	
Kidneys	⬭ yes	⬭ no	/ /	
Liver/Spleen	⬭ yes	⬭ no	/ /	
Bone/Joint	⬭ yes	⬭ no	/ /	
Muscle/Ligament/Tendon	⬭ yes	⬭ no	/ /	
Other	⬭ yes	⬭ no	/ /	

15. Have you ever had heat exhaustion, heat stroke, heat illness, muscle cramps due to heat? ⬭ yes ⬭ no

If yes, please explain

16. During or within 30 minutes of exercise, have you ever:

been dizzy or light-headed?	⬭ yes	⬭ no
passed out (fainted)?	⬭ yes	⬭ no
had chest pain, discomfort or tightness?	⬭ yes	⬭ no
found it more difficult to breath than usual?	⬭ yes	⬭ no
had problems coughing?	⬭ yes	⬭ no

17. Have you ever been told that you have a heart murmur? ⬭ yes ⬭ no

18. Have you ever had racing of your heart, irregular or skipped beats? ⬭ yes ⬭ no

19. Have you ever been told by a physician that you had:

			Explain
high blood pressure?	⬭ yes	⬭ no	
pericarditis, myocarditis, endocarditis?	⬭ yes	⬭ no	
rheumatic fever?	⬭ yes	⬭ no	
other heart or vascular problems? (specify)	⬭ yes	⬭ no	

20. Have you ever had any medical tests for your heart (i.e. EKG, echocardiogram, etc.)? ⬭ yes ⬭ no

If yes, please specify test and reason:

21. Have you ever had a concussion (injury to the head) with or without loss of consciousness? ⬭ yes ⬭ no

If yes, how many times?

⬭ 1X ⬭ 4X

⬭ 2X ⬭ 5X

⬭ 3X ⬭ >5X

22. Have you ever been knocked unconscious? ⬭ yes ⬭ no

If yes, how many times?

⬭ 1X ⬭ 4X

⬭ 2X ⬭ 5X

⬭ 3X ⬭ >5X

What was the longest time you have been unconscious due to a head injury?

⬭ A few seconds

⬭ up to 5 min

⬭ 6-15 min

⬭ >15 min

23. Have you ever had any long term problems due to a head injury (e.g. memory loss, headaches)? ⬭ yes ⬭ no

24. Have you ever had a seizure? ⬭ yes ⬭ no

25. Do you experience migraine headaches? ⬭ yes ⬭ no

26. Do you wear glasses or contact lenses? ⬭ yes ⬭ no

Do you wear glasses or contact lenses when you train or compete? ⬭ yes ⬭ no

If yes, what is your current prescription(s). rt + ☐.☐☐ rt - ☐.☐☐ lt + ☐.☐☐ lt - ☐.☐☐

Have you had your eyes checked in the past 12 months? ⬭ yes ⬭ no

27. Are you legally blind in either of your eyes? ⬭ yes ⬭ no

28. Have you had a serious eye injury? ⬭ yes ⬭ no

If yes, please specify:

WOMEN ONLY, MEN SKIP TO <u>QUESTION #34</u>

29. At what age did your menstrual period start? ☐☐ years of age

30. When was your most recent menstrual period?

⬭ < 1 month ago ⬭ 1-3 months ago ⬭ 4-6 months ago ⬭ > 6 months ago

31. In the past 12 months:

Have you had any trouble with heavy menstrual bleeding? ⬭ yes ⬭ no

Have you had bleeding between periods? ⬭ yes ⬭ no

Have you had menstrual cramps or pain which affected your performance? ⬭ yes ⬭ no

Have you had any unusual discharge from your vagina? ⬭ yes ⬭ no

How many periods have you had? ⬭ 0 ⬭ 1-3 ⬭ 4-6 ⬭ 7-12 ⬭ >12

What was the longest time between periods? ⬭ < 1 mo ⬭ 1-3 mo ⬭ 4-6 mo ⬭ > 6 mo

On average how long has each period lasted? ⬭ 1-5 days ⬭ 6-10 days ⬭ 11-15 days ⬭ > 15 days

32. Are you presently taking any female hormones (estrogen, progesterone, birth control pills) for the purpose of regulating your periods? ⬭ yes ⬭ no

33. Have you ever had a pelvic exam/Pap smear? ⬭ yes ⬭ no

When was your last pelvic exam/Pap smear? ⬭ < 1 year ⬭ 1-3 years ⬭ > 3 years

Was your pelvic exam/Pap smear ever abnormal? ⬭ yes ⬭ no

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MEN ONLY, WOMEN SKIP TO QUESTION #37

34. Were you born with two normal testicles? ⬭ yes ⬭ no

35. Have you ever had surgery to remove or repair a testicle(s)? ⬭ yes ⬭ no

36. Have you ever had a severe testicular injury? ⬭ yes ⬭ no

37. For each full-blood relative listed, please indicate if they have a history of the following. Please select all that apply.

	No family history	Mother/Father	Brother/Sister	Grandparent
High blood pressure	⬭	⬭	⬭	⬭
Heart attack / Heart abnormality	⬭	⬭	⬭	⬭
High blood cholesterol	⬭	⬭	⬭	⬭
Diabetes	⬭	⬭	⬭	⬭
Arthritis	⬭	⬭	⬭	⬭
Bleeding disorder	⬭	⬭	⬭	⬭
Kidney Disease	⬭	⬭	⬭	⬭
Mental Illness	⬭	⬭	⬭	⬭
Sickle Cell Anemia	⬭	⬭	⬭	⬭
Cancer	⬭	⬭	⬭	⬭
Epilepsy	⬭	⬭	⬭	⬭

38. Have you ever experienced chest pain/discomfort associated with exercise? ⬭ yes ⬭ no

39. Have you ever passed out or experienced dizziness associated with exercise? ⬭ yes ⬭ no

40. Have you ever experienced excessive shortness of breath or fatigue associated with exercise? ⬭ yes ⬭ no

41. Have you ever been told by a physician that you have a heart murmur or increased blood pressure? ⬭ yes ⬭ no

42. Does anyone in your family have a history of premature death or significant disability from cardiovascular disease in close relative(s) younger than 50 years old? ⬭ yes ⬭ no

43. Does anyone in your family have a history of hypertrophic cardiomyopathy, dilated cardiomyopathy, long QT symdrome, Marfan Syndrome, or arrhythmias? ⬭ yes ⬭ no

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44. Have you seen a physician, athletic trainer, or other health care professional regarding any new or ongoing injury in the past 12 months? ⬭ yes ⬭ no

45. Do you presently use a brace, splint, sleeve or orthotics for practice or competition? ⬭ yes ⬭ no

46. Have you <u>ever had</u> or do you <u>currently have</u> an injury or problem of the following: (this would include fractures, stress fractures, muscle strains, sprains, tendinitis, bursitis, swelling, etc.) <u>Please include dates!</u>

<u>Neck:</u> ⬭ yes ⬭ no date ☐☐/☐☐/☐☐☐☐

Explain Injury:

<u>Hand, Wrist, Fingers:</u> ⬭ yes ⬭ no date ☐☐/☐☐/☐☐☐☐

Explain Injury:

<u>Spine/Back:</u> ⬭ yes ⬭ no date ☐☐/☐☐/☐☐☐☐

Explain Injury:

<u>Pelvis/Hip:</u> ⬭ yes ⬭ no date ☐☐/☐☐/☐☐☐☐

Explain Injury:

<u>Shoulder/Clavicle:</u> ⬭ yes ⬭ no date ☐☐/☐☐/☐☐☐☐

Explain Injury:

<u>Forearm/Upper Arm:</u> ⬭ yes ⬭ no date ☐☐/☐☐/☐☐☐☐

Explain Injury:

<u>Elbow:</u> ⬭ yes ⬭ no date ☐☐/☐☐/☐☐☐☐

Explain Injury:

<u>Thigh:</u> ⬭ yes ⬭ no date ☐☐/☐☐/☐☐☐☐

Explain Injury:

<u>Knee:</u> ⬭ yes ⬭ no date ☐☐/☐☐/☐☐☐☐

Explain Injury:

<u>Lower Leg:</u> ⬭ yes ⬭ no date ☐☐/☐☐/☐☐☐☐

Explain Injury:

<u>Ankle:</u> ⬭ yes ⬭ no date ☐☐/☐☐/☐☐☐☐

Explain Injury:

<u>Foot/Toes:</u> ⬭ yes ⬭ no date ☐☐/☐☐/☐☐☐☐

Explain Injury:

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47. **In the past 12 months, what is the total number of days of training and competition that you have <u>missed</u> due to an injury?**

# of days	Please Explain

48. **Have you ever had a cortisone injection into a tendon, bursa, or joint for any anjury or pain?** ⬭ yes ⬭ no

If yes, please explain and give date(s):

49. **Have you ever had an x-ray, MRI, CT scan, Bone scan or any other special test for an orthopaedic injury?** ⬭ yes ⬭ no

If yes, please explain and give date(s):

50. **Have you ever had a surgery for a specific orthopaedic injury?** ⬭ yes ⬭ no

If yes, please explain and give date(s):

Surgeon's First Name **Surgeon's Last Name**

Surgeon's Street Address

Surgeon's City **Surgeon's State** **Surgeon's Zip Code**

Surgeon's Telephone **Surgeon's Fax**

51. **Have you ever been hospitalized for any specific injury or illness, other than that listed in question #45?** ⬭ yes ⬭ no

If yes, please explain and give date(s):

52. **Please list any other concerns you would like discussed with the athletic training staff and/or team physicians.**

** ALL STUDENT-ATHLETES WILL HAVE A GENERAL AND ORTHOPAEDIC PHYSICAL EXAMINATION BY THE VANDERBILT UNIVERSITY TEAM PHYSICIANS UPON THEIR ARRIVAL TO CAMPUS.

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.

1. General considerations. Student-athletes diagnosed with ADHD in childhood should provide records of the ADHD assessment and history of treatment. Student-athletes treated since childhood with ADHD stimulant medication but who do not have records of childhood ADHD assessment, or who are initiating treatment as an adult, must undergo a comprehensive evaluation to establish a diagnosis of ADHD. There are currently no formal guidelines or standards of care for the evaluation and management of adult ADHD. The diagnosis is based on a clinical evaluation. ADHD is a neurobiological disorder that should be assessed by an experienced clinician and managed by a physician to improve the functioning and quality of life of an individual.

    a. Student-athletes should have access to a comprehensive continuum of care including educational, behavioral, psychosocial and pharmacological services provided by licensed practitioners who have experience in the diagnosis and management of ADHD. Student-athletes treated with ADHD stimulant medication should receive, at a minimum, annual clinical evaluations.

    b. Mental health professionals who evaluate and prescribe medical therapy for student-athletes with ADHD should have appropriate training and experience in the diagnosis and management of ADHD and should have access to consultation and referral resources, such as appropriate medical specialists.

    c. Primary care professionals providing mental health services (specifically the prescribing of stimulants) for student-athletes with ADHD should have experience in the diagnosis and management of ADHD and should have access to consultation and referral resources (e.g., qualified mental health professionals as well as other appropriate medical specialists).

2. Recommended ways to facilitate academic, athletics, occupational and psychosocial success in the college athlete with adult ADHD taking prescribed stimulants include:

    a. Access to practitioners experienced in the diagnosis and management of adult ADHD.

    b. A timely, comprehensive clinical evaluation and appropriate diagnosis using current medical standards.

c. Access to disability services.

d. Appropriate medical reporting to athletics departments/sports medicine staff.

e. Regular mental health/general medical follow-up.

3. 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.

4. 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).

5. 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.

ATTACHMENT

Attention Deficit Hyperactivity Disorder (ADHD) Guideline Attachment

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:

    - Summary of comprehensive clinical evaluation (referencing DSM-IV criteria) -- attach supporting documentation.
    - ADHD Rating Scale(s) (e.g., Connors, ASRS, CAARS) scores and report summary -- attach supporting documentation.
    - Blood pressure and pulse readings and comments.
    - Note that alternative non-banned medications have been considered, and comments.
    - Diagnosis.
    - Medication(s) and dosage.
    - 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.

NCAA Medical Exception Documentation Reporting Form
to Support the Diagnosis of Attention Deficit Hyperactivity Disorder (ADHD)
and Treatment with Banned Stimulant Medication

- Complete and maintain (on file in the athletics department) this form and required documentation supporting the medical need for a student-athlete to be treated for ADHD with stimulant medication.
- Submit this form and required documentation to Drug Free Sport in the event the student-athlete tests positive for the banned stimulant (see Drug Testing Exceptions Procedures at www.ncaa.org/drugtesting).

To be completed by the Institution:

Institution Name:_____

Institutional Representative Submitting Form:
Name_____
Title_____
Email_____
Phone_____

Student-Athlete Name_____
Student-Athlete Date of Birth_____

To be completed by the Student-Athlete's Physician:

Treating Physician (print name):_____
Specialty:_____
Office address_____
Physician signature:_____ Date_____

Physician documentation (letter, medical notes) to include the following information:

- Diagnosis.
- Medication(s) and dosage.
- Blood pressure and pulse readings and comments.
- Note that alternative non-banned medications have been considered, and comments.
- Follow-up orders.
- Date of clinical evaluation: _____
- **Attach written report summary of comprehensive clinical evaluation:**
  - The evaluation should include individual and family history, address any indication of mood disorders, substance abuse, and previous history of ADHD treatment, and incorporate the DSM criteria to diagnose ADHD. Attach supporting documentation, such as completed ADHD Rating Scale(s) (e.g., Connors, ASRS, CAARS) scores.
  - The evaluation can and should be completed by a clinician capable of meeting the requirements detailed above.

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.

Vanderbilt Sports Medicine

Checklist for Annual Physical Information

Freshman/Transfers

☐ Athlete Registration Form

☐ Signed Parental Consent after reading Parental Responsibility *(bottom of first page on Athlete Registration Form)*

☐ Medical History Form

☐ Copy of Primary Insurance Card—front and back

☐ Copy of Secondary Insurance Card—front and back

☐ Copy of Prescription Medication Insurance Card—front and back

☐ Copy of Dental Insurance Card—front and back

☐ ADHD Documentation *(if prescribed medication for this condition)*

- ADHD Reporting Form included
- Signed Letter from Treating Physician