

# Wheaton College

## Athletic Treatment Center



Primary Care Physician/Health Care Provider:

Wheaton College 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 and 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 present this letter to their primary care physician 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. 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](http://www.ncaa.org/health-safety).

Please return this form to the student-athlete or to the following address or fax number:

Gregory J. Steele  
Head Athletic Trainer  
Wheaton College  
Norton, MA 02766  
Phone: (508) 286-3986  
Fax: (508) 286-5657

Student-Athlete's Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Date of initial evaluation: \_\_\_\_\_ Date of most-recent follow-up: \_\_\_\_\_

Physician's Diagnosis: \_\_\_\_\_

Medication Prescribed/Follow-up Orders: \_\_\_\_\_

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- ✓ 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 attach any alternative 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
- Laboratory/testing results helping to diagnose ADHD/ADD
- Previous ADHD/ADD diagnosis summaries not completed/diagnosed by the current physician

Name of Physician: \_\_\_\_\_

Address: \_\_\_\_\_

Stamp

Specialty: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_