ADD/ADHD POLICY AND NOTIFICATION OF USE

ALL student-athletes that participate in the athletics program are subject to random NCAA drug testing Procedures. Recently, NCAA DRUG TESTING policies have changed regarding student-athletes that take ADD/ADHD medications. This change requires an increase in documentation in order to participate at the intercollegiate level. The majority of ADD/ADHD medications are banned as illegal performance enhancing substances per NCAA rules. Student-athletes who have a documented case of ADD/ADHD with supporting documentation from a physician who has expertise in the area can apply for a medical exemption upon testing positive (drug test) due to the stimulant ADD/ADHD medication.

The Fairleigh Dickinson University Athletic Department must have all the appropriate documentation on file prior to the student-athlete taking the medication. If the student-athlete fails the drug test due to ADD/ADHD medication and does not have all the required documentation already on file with the University, the University will not be able to apply for a medical exemption for the student-athlete.

No student-athlete should ever take any type of prescription medication unless it has been prescribed for them by a physician after a clinical evaluation to determine the medication's use/benefits.

Any student-athlete that takes ADD/ADHD medication bears the responsibility to immediately notify the athletic training room and provide the appropriate documentation. The consequence of a failed drug test without documentation for ADD/ADHD medication is loss of eligibility for 365 days (a full calendar year) from the drug test date.

What to do:

1. Please fill out the **ADD/ADHD NOTIFICATION OF USE FORM** below. This must be returned with physical information regardless of your status with this condition.

2. The evaluation form you should provide to the treating physician should you take any ADD/ADHD medication. This completed form should be on file with the athletic training room prior to the first day of classes for the fall 2016 semester or the first day of practice if practice occurs before classes start.

Should you have any questions after reviewing the information or this letter please feel free to contact the Athletic Training Staff at 201 692-9295.

ADD/ADHD NOTIFICATION OF USE

COMPLETE EITHER SECTION A OR SECTION B

SECTION A

- YES, I _____ currently AM taking or plan to take ADD/ADHD medication
  (Print student-athlete name)

Name medication: _____ Dose:_____ Use: _____

Please initial next to each line:

_____I will provide the FDU athletic training room with my most recent prescription from the prescribing doctor.

_____ I have been provided an ADHD evaluation form for my doctor to complete and **I understand it is required to be on file in the athletic training room prior August 1, 2016.**

_____ _____
(Student-Athlete Signature) Date

****

SECTION B

- NO, I _____ currently do NOT take or plan to take ADD/ADHD medication.
  (Print student-athlete name)

Further, I understand that should I start taking medication for ADD/ADHD I must immediately inform the athletic training room AND provide the appropriate documentation.

_____ _____
(Student-Athlete Signature) Date

Addendum to January 2009 ADHD Treatment
With Banned Stimulants Guidelines - April 1, 2009

****TO BE COMPLETED ONLY IF TAKING ADHD/ADD MEDICATION AND/OR DIAGNOSED WITH ADHD/ADD*****

PHSICIAN FORM FOR ADULT ADHD/ADD EVALUATION - FDU ATHLETIC TRAINING

** Print legibly **

Name (Last, first, M.I,): _____ Circle: MALE FEMALE

Date of Birth (MM/DD/YYYY): _____ Date of Evaluation: _____

Physician Name (PRINT) : _____Specialty: _____

Physician Address: _____

Physician Phone: _____ Physician Fax: _____

CLINICAL EVALUATION- ***there is no across-the-board recommendations for laboratory testing or diagnostic examinations for adult ADHA. The prescribing physician may request testing as individually indicated and appropriate***

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____

EKG* results: (provide most recent):_____

Any additional tests done: NAME(s): _____

*** provide a copy of the results****

ADHD RATING SCALE(s): ATTACH SUPPORTING DOCUMENTATION

☐ ASRS Score: _____ ☐ CAARS Score: _____ ☐ OTHER score: _____

Pertinent History: Personal, Longitudinal, Family: _____

Summary of Clinical Diagnosis (referencing DSM-IV criteria) Attach Supporting Documentation:

HAVE ALTERNATIVE NON BANNED MEDICATIONS BEEN CONSIDERED? ☐ NO ☐ YES

List Prescribed ADHD medications * ATTACH Copy of the Prescription (REQUIRED by the NCAA)**

NAME: _____ DOSE: _____ How Taken: _____
NAME: _____ DOSE:_____ How Taken: _____
NAME: _____ DOSE:_____ How Taken: _____
NAME: _____ DOSE:_____ How Taken: _____

ADDITIONAL EVALUATION COMPONENTS ** attach supporting documents**

ADHD SYMPTOMS REPORT ☐
MENTAL STATUS EXAMINATION REPORTS ☐
Psychological/ Neuropsychological Evaluation/Testing reports ☐
Laboratory Testing Results ☐
Summary of Previous ADHD Diagnosis ☐

PHYSCIAN SIGNATURE: _____ DATE: _____ STAMP: _____