



Cornell University

Cornell Health
Sports Medicine

110 Ho Plaza
Ithaca, New York 14853-3101
t. 607.255.5155
f. 607.255.0269
www.health.cornell.edu

Dear Cornell student athlete:

The NCAA (National Collegiate Athletic Association) requires that all athletes on stimulant medication for the treatment of ADD/ADHD provide adequate documentation of diagnosis and treatment to allow for a medical exception. Stimulant medications are banned for use by NCAA athletes unless medical necessity is clearly documented by their university.

To participate in Cornell Athletics, you must secure the attached documentation from your health care provider. (Submission of this information is required every year of NCAA athletes who require stimulant medications for treatment.)

To meet this requirement, please take the following steps:

1. **Fill in the section at the top of the form** that begins with “To be completed by Cornell student athletes.” If you are under age 18, your parent or guardian also must sign the form. *Your health care provider will not be able to provide this information without your written permission.*
2. **Provide the materials to the clinician** who provides your treatment for ADHD/ADD. Request that he/she complete and return the form and any supporting documentation to you as soon as possible. *It is your responsibility to make sure Cornell Health Sports Medicine receives your form.*
3. **Send the completed form to Cornell Health**
 - **UPLOAD** through myCornellHealth:
 - Go to mycornellhealth.health.cornell.edu
 - From Home Screen, click on “Messages.”
 - Then “New message;” then “Send message or attachment to Health Records.”
 - or FAX: 607.255.0269
 - or MAIL: Cornell Health, Attn: Requirements Office
110 Ho Plaza Ithaca, NY 14853-3101

Timely provision of this information is critical to your participation as a student athlete at Cornell. We greatly appreciate your assistance in complying with NCAA requirements.

Sincerely,

David C. Wentzel, D.O.
Chief of Sports Medicine

Student Name: _____ DOB: ____/____/____

TO BE COMPLETED BY CORNELL STUDENT ATHLETE

I, *(print your name)* _____ give permission to *(print name of health care provider)* _____ to release all information regarding my treatment for ADHD to Cornell Health and 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 Chief of Sports Medicine at Cornell Health, understanding that all information released prior to my revocation is excluded. My signature below indicates that I have read and understand the above statement.

Student Athlete Signature: _____ Date: ____/____/____

Parent/Guardian signature (if under 18 years): _____ Date: ____/____/____

TO BE COMPLETED BY HEALTH CARE PROVIDER

Your patient is a student athlete participating in intercollegiate athletics at Cornell University. The NCAA bans the use of some stimulant medications and requires that the following documentation is submitted each year of the student's participation in an NCAA sport to support a request for a medical exception in the case of a positive drug test for such use.

In addition to test results, please attach test results and any clinical SOAP notes that may help clarify your patient/our athlete's diagnosis of ADHD/ADD and the need for stimulant medications. Return form and additional documentation to your patient to submit to Cornell Health.

1. **Date of ADHD/ADD Diagnosis:** ____/____/____
2. **Required ADHD evaluation components** (Provide copies of test results for the athlete's college medical record/NCAA.)
 - Comprehensive clinical evaluation (using DSM-IV criteria) _____
 - Adult ADHD Rating Scale — e.g., Adult ADHD self-report scale (ASRS), CONNER's Adult ADHD reporting scale (CAARS) Score: _____
 - Monitored blood pressure and pulse _____
 - Alternative non-banned medications that have been considered _____
 - Comments: _____
3. **Additional ADHD evaluation components**
 - Reporting of ADHD symptoms by other significant individual(s): _____
 - Other psychological testing: _____
 - Physical exam date: ____/____/____ Results: _____
 - Laboratory/testing: _____
 - Previous documentation of ADHD diagnosis: _____
 - Other/comments: _____
 - Diagnosis: _____
 - Medication(s) and dosage: _____
4. **The student-athlete will follow-up with me in** (*circle one*): 3 months 6 months 12 months other _____
5. **Physician information**

Name (please print): _____ Date: ____/____/____
Physician Signature: _____ Specialty (MD or DO): _____
Office address: _____
Phone number: _____