

## Forms to take to your Sports Physical

- Pre-participation form MUST be filled out by your doctor and uploaded to Sportsware
  - Upload by going to Forms Section hit ADD-Label as Sports Physical
- Next 3 items only needed to be taken to the doctor IF they pertain to you (These are then mailed back to our trainer Mark Allen)
  - Treatment of diabetes form
  - ADD/ADHD documentation for stimulant
  - Asthma/Anaphylaxis documentation



Western Connecticut State University  
Pre-participation Sports Physical

Must be accompanied by completed medical history and within 6 months of participation.

STUDENT NAME: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
DATE OF EXAM: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ BMI: \_\_\_\_\_ B/P: \_\_\_\_\_ Pulse: \_\_\_\_\_

	Normal	N/A	Abnormal Findings
Appearance			
Skin			
HEENT			
Lymph Nodes			
Heart:			
• Supine			
• Upright			
• Valsalva			
• Squatting			
Lungs			
Abdomen			
Genitalia			
Neuro			
Musculoskeletal:			
• Neck			
• Back			
• Shoulder/Upper Arm			
• Elbow/Forearm			
• Wrist/Hand			
• Hip/Thigh			
• Knee			
• Lower Leg			
• Ankle			
• Foot			

Assessment:

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After review of the attached medical history and examination of the patient, the athlete is:

\_\_\_\_\_ Cleared for full participation in intercollegiate athletics.

\_\_\_\_\_ NOT cleared for athletic participation at this time.

\_\_\_\_\_ Cleared provisionally, but with the following additional specialty clearance, *if indicated by attached WCSU medical history questionnaire:*

Cardiologist signature: \_\_\_\_\_ Date: \_\_\_\_\_

Stamp required: \_\_\_\_\_ Phone: \_\_\_\_\_

Neurologist signature: \_\_\_\_\_ Date: \_\_\_\_\_

Stamp required: \_\_\_\_\_ Phone: \_\_\_\_\_

Orthopedist signature: \_\_\_\_\_ Date: \_\_\_\_\_

Stamp required: \_\_\_\_\_ Phone: \_\_\_\_\_

Examiner's  
signature: \_\_\_\_\_

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

Stamp required:

Phone: \_\_\_\_\_

(WCSU HS 4/2017)



## Western Connecticut State University Athletic Training

William A. O'Neill Athletic & Convocation Center – 181 White Street – Danbury, Connecticut – 06810

Athletic Training Staff: Mark Allen, Patrick Hull, Peter Algarin, and Lindsey Davis

☎ (203) 837-9016, 9032, or 9063 Fax: (203) 837-9050

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Dear Health Care Provider,

Your patient plans to or has already participated in intercollegiate athletics at Western Connecticut State University. As a part of his/her medical clearance the NCAA mandates that any student-athlete taking stimulant medication (s) for treatment of ADD/ADHD provide documentation to allow for a medical exception. The NCAA allows exception to be made for those student-athletes who have a documented medical history demonstrating the need for treatment with a banned drug.

In the event that a student-athlete tests positive during NCAA testing this documentation must be readily available for review. Specific documentation is required so please take the time to review what is being requested and complete the information listed on the attached Medical Exception Documentation Reporting Form.

All information will be collected by the Western Connecticut State University Athletic Training Department and stored in the players file.

Sincerely,

Mark Allen  
Head Athletic Trainer/Professor  
Western Connecticut State University  
WAC Stadium  
West side Campus  
203-837-9016  
[Allenm@wcsu.edu](mailto:Allenm@wcsu.edu)

Send Documentation to:

Mark Allen  
Western Connecticut State University  
181 White St, Danbury, CT. 06810  
WAC Stadium  
West-Side Campus

**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](http://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 \_\_\_\_\_

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

Current Treating Physician (print name): \_\_\_\_\_

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

Office address \_\_\_\_\_

Physician signature: \_\_\_\_\_ Date \_\_\_\_\_

Check off that documentation representing each of the items below is attached to this report

- 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. Please note that this includes the original clinical notes of the diagnostic 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.



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Dear Health Care Provider,

Your patient plans to or has already participated in intercollegiate athletics at Western Connecticut State University. The NCAA (National Collegiate Athletic Association) requires all student-athletes prescribed with stimulant medication(s) for the treatment of asthma/anaphylaxis provide documentation to allow for a medical exemption. The NCAA allows exceptions to be made for those student-athletes who have a documented medical history demonstrating the need for treatment with a banned drug.

Specific documentation is required so please take the time to review and complete the "Medical Exception Asthma/Anaphylaxis Form". This form must be completed and stored in the Western Connecticut State University Athletic Training Room prior to the start of participation and is a part of their medical clearance.

Documents can be given to the student-athlete, their parents (if a minor) or sent to the address listed below.

Sincerely,

Mark Allen  
Head Athletic Trainer/Professor  
Western Connecticut State University  
WAC Stadium  
West side Campus  
203-837-9016  
[Allenm@wcsu.edu](mailto:Allenm@wcsu.edu)

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### Asthma/Anaphylaxis Medical Exception Form

\_\_\_\_\_  
Student-Athlete Name

\_\_\_\_\_  
Date of Birth

\_\_\_\_\_  
Physician Name

\_\_\_\_\_  
Phone Number

\_\_\_\_\_ has been under my care for the treatment of asthma/anaphylaxis since \_\_\_\_\_.

Please provide the following information to better aid our ability to inform the NCAA of the need for this medication.

Explain the current diagnosis:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What is the current medication and dosage:

\_\_\_\_\_  
\_\_\_\_\_

Reason for the medication:

\_\_\_\_\_  
\_\_\_\_\_

Has the student-athlete undergone any formal testing to confirm the diagnosis:

\_\_\_\_\_  
\_\_\_\_\_

Have any alternative non-stimulant medications been considered, or tried with unsatisfactory clinical results:

\_\_\_\_\_  
\_\_\_\_\_

The student-athlete will follow-up with me in \_\_\_\_\_.

\_\_\_\_\_  
Physician Signature

\_\_\_\_\_  
Date

I, student-athlete name) \_\_\_\_\_, give (physician name) permission to release all information regarding my treatment for Asthma/Anaphylaxis to Western Connecticut State University and the NCAA. This authorization is valid for the entirety of my intercollegiate participation at Western Connecticut State University. I may revoke this authorization at any time by submitting a letter in writing to Mark Allen, Head athletic Trainer, with the understanding that all information released prior to my revocation is excluded.

Student-athlete Signature: \_\_\_\_\_

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

Parent/Guardian Signature: \_\_\_\_\_

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





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Date of Birth

Physician Name

Phone Number

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\_\_\_\_\_  
\_\_\_\_\_

What is the current medication and dosage:

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\_\_\_\_\_

Reason for the medication:

\_\_\_\_\_  
\_\_\_\_\_

Has the student-athlete undergone any formal testing to confirm the diagnosis:

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\_\_\_\_\_

Have any alternative non-stimulant medications been considered, or tried with unsatisfactory clinical results:

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