

## Athletic History and Physical Exam for NCAA Intercollegiate Teams & Rugby

**Dear Health Care Provider:**

This form is required for undergraduate students who intend to compete on NCAA Intercollegiate Teams and Rugby. Only those athletes who have completed this exam and immunization requirements will be allowed to practice and compete.

**Name of Student:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

**A. Student intends to compete on these NCAA intercollegiate or Rugby teams (*Mark all that apply.*)**

- |                                     |                                    |                                |                                |                                       |                                  |
|-------------------------------------|------------------------------------|--------------------------------|--------------------------------|---------------------------------------|----------------------------------|
| <input type="radio"/> Baseball      | <input type="radio"/> Equestrian   | <input type="radio"/> Hockey   | <input type="radio"/> Sailing  | <input type="radio"/> Skiing          | <input type="radio"/> Volleyball |
| <input type="radio"/> Basketball    | <input type="radio"/> Field Hockey | <input type="radio"/> Lacrosse | <input type="radio"/> Soccer   | <input type="radio"/> Swimming        |                                  |
| <input type="radio"/> Cross Country | <input type="radio"/> Football     | <input type="radio"/> Rowing   | <input type="radio"/> Softball | <input type="radio"/> Tennis          |                                  |
| <input type="radio"/> Diving        | <input type="radio"/> Golf         | <input type="radio"/> Rugby    | <input type="radio"/> Squash   | <input type="radio"/> Track and Field |                                  |

**B. Medications (*chronic*), please list:**

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**C. Health History (*please mark yes or no*):**

- |                       |                       |  |  |
|-----------------------|-----------------------|--|--|
| <b>Yes</b>            | <b>No</b>             | <b><u>CARDIAC (Personal History)</u></b>   |  |
| <input type="radio"/> | <input type="radio"/> | Exertional chest pain/discomfort   | cardiomyopathy, long-QT syndrome, Marfan's Syndrome or clinically important arrhythmias) |
| <input type="radio"/> | <input type="radio"/> | Unexplained syncope/fainting or near-syncope   |  |
| <input type="radio"/> | <input type="radio"/> | Excessive exertional & unexplained shortness of breath/fatigue associated with exercise                                  |  |
| <input type="radio"/> | <input type="radio"/> | Prior recognition of a heart murmur  |  |
| <input type="radio"/> | <input type="radio"/> | Elevated blood pressure  |  |
| <b>Yes</b>            | <b>No</b>             | <b><u>CARDIAC (Family History)</u></b>   |  |
| <input type="radio"/> | <input type="radio"/> | Premature death due to heart condition (sudden and unexpected) before age 50 years due to heart disease, in one relative |  |
| <input type="radio"/> | <input type="radio"/> | Disability from heart disease in a close relative before age 50 years  |  |
| <input type="radio"/> | <input type="radio"/> | Specific knowledge of certain cardiac conditions in family members (hypertrophic or dilated                              |  |
| <b>Yes</b>            | <b>No</b>             | <b><u>NEUROLOGICAL</u></b>   |  |
| <input type="radio"/> | <input type="radio"/> | Concussion(s) (If yes, list number including dates in comment section.)  |  |
| <input type="radio"/> | <input type="radio"/> | Migraine headaches   |  |
| <input type="radio"/> | <input type="radio"/> | Head/Neck injuries   |  |
| <input type="radio"/> | <input type="radio"/> | History of Seizures  |  |
| <b>Yes</b>            | <b>No</b>             | <b><u>MARFAN'S SYNDROME</u></b>  |  |
| <input type="radio"/> | <input type="radio"/> | Known personal history of Marfan's Syndrome  |  |
| <input type="radio"/> | <input type="radio"/> | Known family history of Marfan's Syndrome  |  |

<b>Yes</b>	<b>No</b>	<b><u>GENERAL</u></b>
<input type="radio"/>	<input type="radio"/>	Chronic illness(es)
<input type="radio"/>	<input type="radio"/>	Exercise induced bronchospasm/asthma
<input type="radio"/>	<input type="radio"/>	Joint instability/joint surgery
<input type="radio"/>	<input type="radio"/>	Eating disorder
<input type="radio"/>	<input type="radio"/>	Other medical or psychological issues or concerns

<b>Yes</b>	<b>No</b>	<b><u>GENERAL</u></b>
<input type="radio"/>	<input type="radio"/>	Heat-related illness
<input type="radio"/>	<input type="radio"/>	Loss of paired organ
<input type="radio"/>	<input type="radio"/>	History of bleeding disorder
<input type="radio"/>	<input type="radio"/>	Severe anemia

**Please comment on any yes answers in this section.**

**D. Athletic Physical Exam**

Height \_\_\_\_\_ in      Weight \_\_\_\_\_ lbs      Resting Pulse (bpm) \_\_\_\_\_

Blood Pressure: \_\_\_\_\_ / \_\_\_\_\_      Right Arm      \_\_\_\_\_ / \_\_\_\_\_      Left Arm

<b>Normal/No</b>	<b>Abnormal/Yes</b>	
<input type="radio"/>	<input type="radio"/>	Cranial Nerves (II-XII)
<input type="radio"/>	<input type="radio"/>	Heart
<b>No</b>	<b>Yes</b>	Does the patient have a heart murmur?
<b>No</b>	<b>Yes</b>	Does the patient have a cardiac arrhythmia?
<b>No</b>	<b>Yes</b>	Does the patient have physical stigmata of Marfan's Syndrome*?

<b>Normal/No</b>	<b>Abnormal/Yes</b>		<b>Normal/No</b>	<b>Abnormal/Yes</b>	
<input type="radio"/>	<input type="radio"/>	Lungs	<input type="radio"/>	<input type="radio"/>	Neck/Back
<input type="radio"/>	<input type="radio"/>	Abdomen	<input type="radio"/>	<input type="radio"/>	Shoulders
<input type="radio"/>	<input type="radio"/>	Balance/Coordination	<input type="radio"/>	<input type="radio"/>	Arms/Wrists/Hands
<input type="radio"/>	<input type="radio"/>	Skin	<input type="radio"/>	<input type="radio"/>	Hips/Knees/Feet
<input type="radio"/>	<input type="radio"/>	Oral Cavity/Teeth	<input type="radio"/>	<input type="radio"/>	Reflexes
<input type="radio"/>	<input type="radio"/>	Eyes/Ears/Hearing	<input type="radio"/>	<input type="radio"/>	Femoral Pulses
<b>No</b>	<b>Yes</b>	Glasses or contacts?	<b>No</b>	<b>Yes</b>	Hernia
			<b>Men Only</b>	<input type="radio"/>	
			<input type="radio"/>	<input type="radio"/>	Genitalia/Testicles

**Additional Comments:**

**E. ADHD Treatment**

**Yes**      **No**      Is the student currently taking prescribed medication for Attention Deficit Hyperactivity Disorder (ADHD)?

If yes, please refer to enclosed letter and form about NCAA guidelines on banned substances.

**F. Medical Clearance**

**IMPORTANT**

**Yes      No**

      In your opinion, is this student medically able to participate in intercollegiate sports?\*

      Are additional test results or cardiology consults pending? If so please send results when available.

**\*NOTE TO PROVIDER:**

In order to clear this student to compete in intercollegiate athletics, we require the following test(s) for abnormalities noted above or clearance by a board certified cardiologist or other specialist. Please send test results or documentation from the cardiologist or other specialist that the student is medically able to participate in intercollegiate athletic competition. The student will not be able to practice or compete in an intercollegiate sport until testing for abnormalities or specialist clearance is documented for the Health Service.

**1. Obtain/Submit report of an echocardiogram if:**

- There is a heart murmur that has not already been documented to be benign;
- The student has a history of light-headedness, syncope, chest pain, or significant dyspnea with exercise;
- Symptomatic palpitations or other arrhythmias;
- There is documented Marfan's Syndrome or suspected Marfan's based on body habitus including arm span > height, men 6'4" or taller, women 6'0" or taller, kyphoscoliosis, pectus excavatum, cardiac murmur or midsystolic click, joint laxity;
- Family history of sudden cardiac death;
- Family history of hypertrophic obstructive cardiomyopathy.

**2. Obtain/Submit report of a Holter monitor or cardiac event monitor if fainting or dizziness occurs with exertion.**

**3. Obtain/Submit report of an exercise treadmill test in cases of known coronary artery disease, chest pain or excessive dyspnea with exertion.**

**4. A letter from a board certified cardiologist supporting sports clearance to compete in intercollegiate sports will be considered as a substitute for additional testing.**

**Examiner's signature is required**

Provider Name (please print): \_\_\_\_\_

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

Phone Number (    ) \_\_\_\_\_

(Circle one please)    **MD    DO   PA   NP**

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



**Dartmouth College** HANOVER • NEW HAMPSHIRE • 03755

*Health Service, Dick Hall's House, 7 Rope Ferry Road* TELEPHONE: (603) 646-9400

June 2009

Dear Health Care Provider,

Your patient, a student-athlete at Dartmouth College, plans to or already participates in intercollegiate athletics at our institution. 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 exemption. Stimulant medications are typically banned for use by NCAA athletes unless medical necessity is clearly documented by the host university. The Dartmouth College Health Service is requesting the following information in order for your student-athlete to continue or begin their NCAA participation. This is critical for his/her participation in sports.

Please complete the enclosed form that will be required annually if your patient participates in NCAA athletics and continues to require stimulant medications for his/her treatment. In completing this paperwork, you acknowledge that you have reviewed the patient's health history and provided safety information regarding stimulant use as well as misuse guidelines. Please attach any consult letters or SOAP notes that may clarify the diagnosis and the need to use stimulant medications for treatment.

We greatly appreciate your assistance as we try to comply with NCAA requirements.

Sincerely yours,

John H. Turco, M.D.  
Director  
Dartmouth College Health Service

**Please send documentation to:**

John H. Turco, M.D.  
Attention: Medical Records  
Dartmouth College Health Service  
7 Rope Ferry Road  
Hanover, NH 03755



Medical Exception ADHD / ADD

Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Name of Athlete: \_\_\_\_\_ Date of Birth \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Provider: Your patient is a student-athlete participating in intercollegiate athletics. The NCAA bans the use of some stimulant medications and requires that the following documentation is submitted to support a request for a medical exception in the case of a positive drug test for such use. For additional information, please visit the NCAA Health & Safety website

http://www.ncaa.org/wps/ncaa?ContentID=481

Date of Clinical Evaluation: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Required ADHD evaluation components

- o Comprehensive clinical evaluation (using DSM-IV criteria) \_\_\_\_\_
o Adult ADHD Rating Scale (e.g., Adult ADHD self report scale (ASRS), CONNER's Adult ADHD reporting scale (CAARS) Score: \_\_\_\_\_
o Monitored blood pressure and pulse \_\_\_\_\_
o Alternative non-banned medications that have been considered:

\*\*please submit copies of test results for the athlete's college medical record/NCAA\*\*

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: \_\_\_\_\_

The student-athlete will follow-up with me in (circle one):

3 months, 6 months, 12 months, other \_\_\_\_\_

Physician Name (Printed): \_\_\_\_\_ (MD or DO) Date: \_\_ / \_\_ / \_\_\_\_

Physician Signature: \_\_\_\_\_ Specialty: \_\_\_\_\_

Office Address: \_\_\_\_\_ Tel #: \_\_\_\_\_

*Please feel free to attach any clinical SOAP notes that may help clarify your patient/ our athlete's diagnosis of ADHD/ADD and the need for stimulant medications.*

**Student Athletes - Please complete the following:**

I, \_\_\_\_\_, give \_\_\_\_\_ permission to release all information regarding my treatment for ADHD to the Dartmouth College Health Service 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 Director of the Dartmouth College Health Service, understanding that all information released prior to my revocation is excluded. My signature below indicates that I have read and understand the above statement.

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

Parent/Guardian Signature (if under 18 years): \_\_\_\_\_ Date: \_\_\_\_\_