SAINT LOUIS
SPORTS MEDICINE

Dear Freshman / First Year Transfer Participants,

On behalf of the Sports Medicine Department we want to welcome you to Saint Louis University and look forward to working with you this season.

Physical examinations are required for first-time participants who wish to participate on an intercollegiate athletics team at Saint Louis University. For first time student-athletes, please read and complete the Student-Athlete Policy Overview, Acknowledgment of Insurance Form (copy of insurance cards), Student/Family Information Form, Health History Questionnaire, Authorization for Release of Protected Health Information, ADHD/ADD Medical Exception (if needed) and Supplement Notification Form (if needed). Additionally, a team physician will complete and sign the Student-Athlete Physical Examination form. These are the only eligible forms that will be accepted and must be on file in the student-athlete's medical chart prior to participating in any intercollegiate sport activity. No student-athlete will be permitted to participate, in any way, until all referrals, or recommendations by the examining physician are completed, and the physician has signed and approved his/her eligibility for participation. **THERE ARE NO EXCEPTIONS TO THIS POLICY**.

Saint Louis University provides opportunities for student-athletes to receive a physical examination on campus by our team physi-cian through the Student Health Center. If you are going to be on campus during the summer and would like to get your physical exam, please contact your sport's assigned athletic trainer to schedule your appointment. The Student Health Center accepts most insurance plans. It is the responsibility of the student-athlete to submit bills associated with the physical examination to his/her in-surance carrier for consideration. Please see medical billing policy for more details. (SLU Athletics will provide payment for physicals **after** the individual's primary insurance is billed.)

All medical results are subject to final approval by the Saint Louis University team physician. The NCAA recommends that all student athletes be aware of their sickle cell status. If the student athlete does not know whether they are positive for sickle cell trait, the NCAA recommends that student athletes undergo testing to determine their status. (Please see the Sickle Cell Information Sheet.) All medical records on file in the athletic training room become confidential property of Saint Louis University Athletics Department and cannot be used for non-athletic purposes.

Should you develop a significant injury or illness after your physical examination, but before the first sanctioned practice, you must present, to the Saint Louis athletic training staff, a letter from a qualified physician stating you are eligible to be cleared by a Saint Louis University team physician to participate in intercollegiate sports activities.

All completed medical forms and insurance form must be submitted by August 1, 2019.

If you have any questions, contact Jonathan Burch via e-mail at jonathan.burch@slu.edu.

Mail to:
Jonathan Burch
Director of Sports Medicine
Saint Louis University
Chaifetz Arena – Sports Medicine
3330 Laclede Avenue
St. Louis, MO 63103
jonathan.burch@slu.edu

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SAINT LOUIS
SPORTS MEDICINE

POLICY OVERVIEW

NCAA INFORMATION FOR DRUG TESTING MEDICAL EXCEPTIONS

Beginning August 1, 2009, the NCAA has indicated that there will be a stricter application of the NCAA Medical Exception Policy as it applies to banned stimulant medications used to treat Attention Deficit Hyperactivity Disorder (ADHD). This stricter application will require documentation that demonstrates the student athlete has undergone a clinical assessment to diagnose ADHD, is being monitored regularly for use of the stimulant medication, and has a current prescription on file.

These documentation requirements are very stringent. Refer to the attached "Athletic Training Room – NCAA Information for Drug Testing Medical Exceptions" form and complete in its entirety. Additional information can be found at www.ncaa.org.

SICKLE CELL STATUS

The NCAA recommends that all student athletes be aware of their sickle cell status. If the student athlete does not know whether they are positive for sickle cell trait, the NCAA recommends that student athletes undergo testing to determine their status.

Saint Louis University is supportive of this recommendation, and requests that each student provide Sports Medicine with documentation of their sickle cell trait status. To help you make an informed decision regarding this issue, some basic information is provided in the attached "Sickle Cell Trait Information Sheet" and at the additional resource links referenced on that information sheet.

CONCUSSION INFORMATION

Saint Louis University wants its student athletes to be aware of the risks of concussion associated with participation in intercollegiate athletics, and is therefore providing the attached information about the risks and symptoms of concussions. My signature below acknowledges that I have received this educational information and that I specifically agree that I will immediately report to Saint Louis University if I experience any symptoms of concussion.

ASSUMPTION OF RISK

I am aware that participating in athletic activity involves risks of injury, including, but not limited to the potential for catastrophic injury. I understand that the dangers and risks of participation in athletic activity include, but are not limited to, death, serious neck and spinal injuries which may result in complete or partial paralysis or brain damage, serious injury to virtually all bones, joints, ligaments, muscles, tendons, and other aspects of the muscular-skeletal system, and serious injury or impairment to other aspects of my body, general health and well-being. Furthermore, I understand that the possibility of injury, including catastrophic injury, is beyond Saint Louis University's control, and exists even though proper rules and techniques are followed. I also understand that there are risks involved with travel in connection with intercollegiate athletics. I acknowledge that my decision to participate in athletic activity at Saint Louis University is voluntary, and in consideration of Saint Louis University permitting me to participate in intercollegiate athletics, I agree to assume all risks associated with participation and agree to hold harmless, indemnify, and irrevocably and unconditionally release Saint Louis University and its officers, agents, and employees from any and all liability, any medical expenses not covered by Saint Louis University Department of Athletics medical insurance policies, and any and all claims, causes of action or demands of any kind and nature whatsoever which may arise by or in connection with my participation in any activities related to intercollegiate athletics, except to the extent such claims are solely caused by the negligence or intentionally willful actions of Saint Louis University.

DISCLOSURE OF PHYSICAL CONDITION

Recognizing that an assessment of my physical condition is dependent upon my providing an accurate medical history and fully disclosing any symptoms, complaints, prior injuries, ailments, and/or disabilities I have experienced, I agree that I will fully disclose in writing my prior medical history by accurately completing this Health History Questionnaire Form and by providing any supplemental materials necessary to present Saint Louis University with complete information about my medical history. I understand that it is also my responsibility to report to the Sports Medicine Department any present symptoms, complaints, ailments, and disabilities, and to report immediately any new health issues that may arise while I am a student athlete at Saint Louis University.

By signing below, I confirm that I have read and understand the above, that I am not suffering from any complaints, prior injuries, ailments, disabilities, conditions, or health problems not disclosed and discussed to Saint Louis University's Sports Medicine Department. I acknowledge and agree that all future injuries, medical, dental, or mental health problems, ailments, complaints, re-injuries, and aggravations of old injuries must be immediately and directly reported to the Saint Louis University's Team Physician, the Head Athletic Trainer, and/or the member of the Saint Louis University Athletic Training staff specifically assigned to my team, no matter how minor or insignificant I may deem the health issue.

STUDENT-ATHLETE SIGNATURE / ELECTRONIC SIGNATURE (Please type your first and last name) DATE

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

SAINT LOUIS
SPORTS MEDICINE

HEALTH HISTORY QUESTIONNAIRE

Name _____ Sex ☐ F ☐ M Age _____ Birth date _____

Banner ID# _____ Sport _____

Local address _____ Local phone _____

Permanent address:

Street _____ City / State / Zip _____

Phone _____ Cell phone _____

Email address _____

Father's name _____ Age _____

If deceased, cause of death _____ Age @ death _____

Father's occupation _____

Address (if different from permanent address):

Street _____ City / State / Zip _____

Home phone _____ Work phone _____

Mother's Name _____ Age _____

If deceased, cause of death _____ Age @ death _____

Mother's occupation _____

Address (if different from permanent address):

Street _____ City / State / Zip _____

Home phone _____ Work phone _____

IN CASE OF EMERGENCY, CONTACT: Name _____

Relationship _____ Phone (h) _____ Phone (w/c) _____

Personal Physician _____ Physician phone _____

Have any of your relatives had:

			RELATIONSHIP				RELATIONSHIP
• Asthma	☐ YES	☐ NO	_____	• Heart Disease	☐ YES	☐ NO	_____
• Arthritis	☐ YES	☐ NO	_____	• Kidney Disease	☐ YES	☐ NO	_____
• Cancer	☐ YES	☐ NO	_____	• Stomach Trouble	☐ YES	☐ NO	_____
• Diabetes	☐ YES	☐ NO	_____	• Stroke	☐ YES	☐ NO	_____
• Epilepsy	☐ YES	☐ NO	_____	• Tuberculosis	☐ YES	☐ NO	_____

SAINT LOUIS
SPORTS MEDICINE

Student-Athlete Name _____

1. CARDIOVASCULAR RISK FACTORS

Have you ever had chest pain, dizziness, fainting and/or shortness of breath during or after exercise / practice? ☐ YES ☐ NO

- Please describe _____

Have you ever been told that you have a heart murmur? ☐ YES ☐ NO

- Please describe _____

Does anyone in your family have Marfan Syndrome? ☐ YES ☐ NO

- Please describe _____

Has any family member or relative died of heart problems and/or of sudden death before age 50? ☐ YES ☐ NO

- Please describe _____

Has a physician ever denied or restricted your participation in sports due to any heart / cardiovascular problems? ☐ YES ☐ NO

- Please describe _____

Have you ever had an electrocardiogram (EKG) and/or echocardiogram (ECHO) of your heart? ☐ YES ☐ NO

- Dates / please describe _____

Do you or anyone in your family have a history of high blood pressure? ☐ YES ☐ NO

- Please describe _____

Do you or anyone in your family have a history of high blood cholesterol? ☐ YES ☐ NO

- Please describe _____

2. ALLERGIES

Have you ever been diagnosed with any allergies or had any unfavorable reactions to foods, insects and/or drugs? ☐ YES ☐ NO

- Please describe _____

Are you presently taking / have you previously taken any allergy medications? ☐ YES ☐ NO

- Please describe _____

Have you ever had a rash or hives develop during and/or after exercise? ☐ YES ☐ NO

Do you cough, wheeze, have chest tightness, have shortness of breath, or have trouble breathing during or after exercise / practice, at night, or after exposure to allergens / pollutants? ☐ YES ☐ NO

Have you ever been prescribed an epi pen? ☐ YES ☐ NO

3. ASTHMA

Have you ever been diagnosed with asthma and/or exercised induced asthma? ☐ YES ☐ NO

- Please describe (include dates and details) _____

Are you presently taking / have you previously taken any asthma medications / use an inhaler? ☐ YES ☐ NO

- Date(s)? Type of medication _____

Have you ever been advised not to participate in athletic activities due to asthma or any related condition? ☐ YES ☐ NO

- Please describe _____

SAINT LOUIS
SPORTS MEDICINE

Student-Athlete Name _____

4. HEAD INJURIES / CONCUSSION

Have you ever suffered a head injury / concussion (no matter how minor)? ☐ YES ☐ NO

- Please describe (include dates and details): _____

Have you ever been evaluated by a doctor for a head injury / concussion? ☐ YES ☐ NO

- Please describe _____
- Were any diagnostic tests performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan

Have you ever been hospitalized, knocked out, and/or suffered memory loss to a head injury / concussion? ☐ YES ☐ NO

- Please describe (include dates and details) _____

Have you ever been advised not to participate in athletic activities due to a head injury / concussion? ☐ YES ☐ NO

- Please describe _____

5. EYE

Do you have any problems with your vision? ☐ YES ☐ NO

- Please describe _____

When was your last eye exam? _____

- Findings? _____

Have you ever suffered an injury to your eye(s) and/or been advised that you have an eye disease? ☐ YES ☐ NO

- List date(s) / time (e.g. practices or games) missed _____

Do you routinely wear glasses and/or contact lenses? ☐ YES ☐ NO

6. EAR / NOSE / THROAT

Have you ever suffered an injury to your ear(s), nose and/or throat? ☐ YES ☐ NO

- Please explain and list date(s) / time (e.g. practices or games) missed _____
- Were any diagnostic tests performed? ☐ YES ☐ NO If yes, please list _____

Have you ever been hospitalized for an ear, nose, and/or throat injury? ☐ YES ☐ NO

Have you ever been advised not to participate in athletic activities due to an ear, nose, and/or throat injury? ☐ YES ☐ NO

- Please describe _____

7. DENTAL

When was your last dental exam? _____

- Findings? _____

Have you ever suffered an injury to your mouth, jaw, and/or teeth? ☐ YES ☐ NO

- Please explain and list date(s) / time (e.g. practices or games) missed _____

SAINT LOUIS
SPORTS MEDICINE

Student-Athlete Name _____

8. CERVICAL SPINE / NECK

Have you ever suffered an injury to your cervical spine and/or neck? ☐ YES ☐ NO

- Please explain and list date(s) / time (e.g. practices or games) missed _____
- Were any diagnostic tests performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have you ever been hospitalized for a cervical spine / neck injury? ☐ YES ☐ NO

- Please describe (include location and date): _____

Have you ever had "numbness," "tingling," "burners," "stingers," or brachial plexus injuries? ☐ YES ☐ NO

- How many? Date(s)/time missed? _____

Have you ever been advised not to participate in athletic activities due to a cervical spine / neck injury? ☐ YES ☐ NO

- Please describe _____

9. SHOULDER / ARM / ELBOW / WRIST / HAND

Have you ever suffered an injury to your shoulder / arm / elbow / wrist / hand? ☐ YES ☐ NO

- Please explain and list date(s) / time (e.g. practices or games) missed _____
- Were any diagnostic tests performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have you ever had surgery of any kind on your shoulder / arm / elbow / wrist / hand? ☐ YES ☐ NO

- Please describe (include dates and details): _____

Have you ever been advised not to participate in athletic activities due to a shoulder / arm / elbow / wrist / hand injury? ☐ YES ☐ NO

- Please describe _____

10. SPINE / LOW BACK / SACROILIAC JOINT

Have you ever suffered an injury to your spine / low back / sacroiliac joint? ☐ YES ☐ NO

- Please describe (include dates and details) _____
- Were any diagnostic tests performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have you ever had surgery of any kind on your spine / low back / sacroiliac joint? ☐ YES ☐ NO

- Please describe (include dates and details) _____

Have you ever been advised not to participate in athletic activities due to a spine, low back, or SI joint injury? ☐ YES ☐ NO

- Please describe _____

11. HIP / GROIN

Have you ever suffered an injury to your hip / groin (including hernias and/or sports hernias)? ☐ YES ☐ NO

- Please describe (include dates and details) _____
- Were any diagnostic tests performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have you ever had surgery for a hip / groin injury? ☐ YES ☐ NO

- Please describe (include dates and details) _____

Have you ever been advised not to participate in athletic activities due to a hip and/or groin injury? ☐ YES ☐ NO

- Please describe _____

SAINT LOUIS
SPORTS MEDICINE

Student-Athlete Name _____

12. THIGH / HAMSTRING / QUADRICEPS

Have you ever suffered an injury to your thigh, hamstring, and/or quadriceps? ☐ YES ☐ NO

- Please describe (include dates and details) _____
- Were any diagnostic tests performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have you ever been advised not to participate in athletic activities due to a thigh, hamstring, or quadriceps injury? ☐ YES ☐ NO

- Please describe _____

13. KNEE / PATELLA

Have you ever suffered an injury to your knee and/or patella (kneecap)? ☐ YES ☐ NO

- Please describe (include dates and details) _____
- Were any diagnostic tests performed? (check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have you ever had surgery for a knee and/or patella injury? ☐ YES ☐ NO

- Please describe (include dates and details) _____

Have you ever been advised not to participate in athletic activities due to a knee / patella injury? ☐ YES ☐ NO

- Please describe _____

14. ANKLE / LOWER LEG / FOOT

Have you ever suffered an injury to your ankle / lower leg or foot? ☐ YES ☐ NO

- Please describe (include dates and details) _____
- Were any diagnostic tests performed? (Check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have you ever had surgery for an ankle / lower leg / foot injury? ☐ YES ☐ NO

- Please describe (include dates and details) _____

Have you ever been advised not to participate in athletic activities due to an ankle / lower leg / foot injury? ☐ YES ☐ NO

15. ABDOMEN / RIBS / THORAX / CHEST

Have you ever suffered an injury to your abdomen / rib / thorax / chest? ☐ YES ☐ NO

- Please describe (include dates and details) _____
- Were any diagnostic tests performed? (Check all that apply) ☐ X-Rays ☐ MRI ☐ CT-Scan ☐ Bone Scan

Have you ever had surgery for a rib / thorax / chest injury? ☐ YES ☐ NO

- Please describe (include dates and details) _____

Have you ever been advised not to participate in athletic activities due to a ribs, thorax, and/or chest injury? ☐ YES ☐ NO

- Please describe _____

16. MEDICAL TESTING

Have you ever been diagnosed with a Communicable Disease
(e.g. STD, HIV, Hepatitis A, B, or C, Herpes Simplex, Syphilis, Tuberculosis)? ☐ YES ☐ NO

- Please describe _____

SAINT LOUIS
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Student-Athlete Name _____

17. DERMATOLOGICAL (SKIN)

Do you have any skin problems that we should be aware of
(e.g. ringworm, herpes, skin infection, itching, rashes, acne, warts, eczema, fungus, etc.)? ☐ YES ☐ NO

- Please describe _____

Have you ever been diagnosed with a staph infection and/or MRSA infection on any part of your body? ☐ YES ☐ NO

- Please describe _____

Have you ever been under the care of a dermatologist for any condition? ☐ YES ☐ NO

18. PRESCRIPTION MEDICATIONS

Please list ALL Prescription & Over-the-Counter Medications that you are CURRENTLY taking or have taken in the past 2 years, and for what purpose:

MEDICATION	PURPOSE	DOSAGE	DATE(S)

19. SUPPLEMENTS / ERGOGENIC AIDS

Please list ALL supplements / ergogenic aids that you are CURRENTLY taking or have taken in the PAST 2 years, and for what purpose:

SUPPLEMENT	PURPOSE	DOSAGE	DATE(S)

☐ YES ☐ NO I have taken supplements to help me gain or lose weight.

20. HEAT RELATED PROBLEMS

Have you ever suffered from a heat related injury? ☐ YES ☐ NO

(check all that apply):

☐ YES ☐ NO Heat Cramps Date(s) _____

☐ YES ☐ NO Heat Syncope (Fainting) Date(s) _____

☐ YES ☐ NO Heat Exhaustion Date(s) _____

☐ YES ☐ NO Heat Stroke Date(s) _____

Have you ever been hospitalized for a heat-related problem? ☐ YES ☐ NO

- Date(s)? Where? _____

Have you ever been advised not to participate in athletic activities due to a heat related injury? ☐ YES ☐ NO

- Please Describe _____

SAINT LOUIS
SPORTS MEDICINE

Student-Athlete Name _____

21. DIABETIC HISTORY

Have you ever been diagnosed with Diabetes? ☐ YES ☐ NO

- Date? _____

Are you presently taking or have you taken any Diabetic medications? ☐ YES ☐ NO

MEDICATION	FORM	DOSAGE	FREQUENCY

Please list any precautions that you take and/or additional information not mentioned above _____

_____

22. SICKLE CELL ANEMIA

Have you ever been tested for Sickle Cell Anemia that you are aware of? ☐ YES ☐ NO ☐ DON'T KNOW

- Date? Result? _____

The NCAA recommends that all student athletes be aware of their sickle cell status. If you checked "don't know" above, please review the attached Sickle Cell Information Sheet, and arrange for sickle trait testing.

Does any member of your family carry the Sickle Cell Trait / have Sickle Cell Anemia that you are aware of? ☐ YES ☐ NO

- Please Describe _____

23. FEMALES ONLY

At what age did you have your first menstrual period? _____When was your most recent menstrual period? _____

How much time do you usually have from the start of one period to the start of the next? _____

☐ YES ☐ NO Has your menstrual period changed appearance within the past 6 months? _____

What was the longest time between periods in the past year? _____

☐ YES ☐ NO Have you had menstrual periods within the past 12 months? If yes, how many? _____

☐ YES ☐ NO Do you take birth control pills? Brand _____

☐ YES ☐ NO Do you take any medications during your menstrual periods? If yes, what? _____

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Student-Athlete Name _____

24. MENTAL HEALTH

SECTION 1

I often have trouble sleeping.	☐ YES	☐ NO
I wish I had more energy most days of the week.	☐ YES	☐ NO
I think about things over and over.	☐ YES	☐ NO
I feel anxious and nervous much of the time.	☐ YES	☐ NO
I often feel sad or depressed.	☐ YES	☐ NO
I struggle with being confident.	☐ YES	☐ NO
I don't feel hopeful about the future.	☐ YES	☐ NO
I have a hard time managing my emotions (frustration, anger, impatience).	☐ YES	☐ NO
I have feelings of hurting myself or others.	☐ YES	☐ NO

SECTION 2

Do you make yourself sick because you feel uncomfortably full?	☐ YES	☐ NO
Do you worry that you have lost control over how much you eat?	☐ YES	☐ NO
Have you recently lost more than 15 pounds in a 3-month period?	☐ YES	☐ NO
Do you believe yourself to be fat when others say you are thin?	☐ YES	☐ NO
Would you say food dominates your life?	☐ YES	☐ NO

SECTION 3

Please answer using the following scale:
0=None or a little of the time; **1**=Some of the time;
2=Most of the time; **3**=All of the time

Over the past two weeks, how often have you:

Been feeling low in energy, slowed down?	☐ 0	☐ 1	☐ 2	☐ 3
Blamed yourself for things?	☐ 0	☐ 1	☐ 2	☐ 3
Had poor appetite?	☐ 0	☐ 1	☐ 2	☐ 3
Had difficulty falling asleep, staying awake?	☐ 0	☐ 1	☐ 2	☐ 3
Been feeling hopeless about the future?	☐ 0	☐ 1	☐ 2	☐ 3
Been feeling blue?	☐ 0	☐ 1	☐ 2	☐ 3
Had feelings of no interest in things?	☐ 0	☐ 1	☐ 2	☐ 3
Had feelings of worthlessness?	☐ 0	☐ 1	☐ 2	☐ 3
Thought about or wanted to commit suicide?	☐ 0	☐ 1	☐ 2	☐ 3
Had difficulty concentrating or making decisions?	☐ 0	☐ 1	☐ 2	☐ 3

SECTION 4

Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by indicating the response option using:
0=not at all; **1**=mildly but it didn't bother me much;
2=moderately – it wasn't pleasant at times;
3=severely – it bothered me a lot

Numbness or tingling	☐ 0	☐ 1	☐ 2	☐ 3
Feeling hot	☐ 0	☐ 1	☐ 2	☐ 3
Wobbliness in legs	☐ 0	☐ 1	☐ 2	☐ 3
Unable to relax	☐ 0	☐ 1	☐ 2	☐ 3
Fear of worst happening	☐ 0	☐ 1	☐ 2	☐ 3
Dizzy or lightheaded	☐ 0	☐ 1	☐ 2	☐ 3
Heart pounding/racing	☐ 0	☐ 1	☐ 2	☐ 3
Unsteady	☐ 0	☐ 1	☐ 2	☐ 3
Terrified or afraid	☐ 0	☐ 1	☐ 2	☐ 3
Nervous	☐ 0	☐ 1	☐ 2	☐ 3
Feeling of choking	☐ 0	☐ 1	☐ 2	☐ 3
Hands trembling	☐ 0	☐ 1	☐ 2	☐ 3
Shaky/unsteady	☐ 0	☐ 1	☐ 2	☐ 3
Fear of losing control	☐ 0	☐ 1	☐ 2	☐ 3
Difficulty in breathing	☐ 0	☐ 1	☐ 2	☐ 3
Fear of dying	☐ 0	☐ 1	☐ 2	☐ 3
Scared	☐ 0	☐ 1	☐ 2	☐ 3
Indigestion	☐ 0	☐ 1	☐ 2	☐ 3
Faint/lightheaded	☐ 0	☐ 1	☐ 2	☐ 3
Face flushed	☐ 0	☐ 1	☐ 2	☐ 3
Hot/cold sweats	☐ 0	☐ 1	☐ 2	☐ 3

SECTION 5

Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?	☐ YES	☐ NO
Do you often feel tired, fatigued, or sleepy during daytime?	☐ YES	☐ NO
Has anyone observed you stop breathing during your sleep?	☐ YES	☐ NO
Do you have or are you being treated for high blood pressure?	☐ YES	☐ NO

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Student-Athlete Name _____

24. MENTAL HEALTH (CONTINUED)

SECTION 6

Please rate the current (i.e. last 2 weeks) **severity** of your insomnia problem(s).

Difficulty falling asleep	☐ none	☐ mild	☐ moderate	☐ severe	☐ very
Difficulty staying asleep	☐ none	☐ mild	☐ moderate	☐ severe	☐ very
Problem waking up too early	☐ none	☐ mild	☐ moderate	☐ severe	☐ very
How **satisfied**/disappointed are you with your current sleep pattern?			☐ very satisfied	☐ very dissatisfied	

To what extent do you consider your sleep problems to **interfere** with your daily functioning (e.g. daytime fatigue, ability to function at work/daily chores, concentration, memory, mood, etc.)?	☐ not at all interfering	☐ a little	☐ somewhat	☐ much	☐ very much interfering
How **noticeable** to others do you think your sleeping problem is in terms of impairing the quality of your life?	☐ not at all noticeable	☐ a little	☐ somewhat	☐ much	☐ very much noticeable
How **worried**/distressed are you about your current sleep problem?	☐ not at all	☐ a little	☐ somewhat	☐ much	☐ very much

SECTION 7

Select the response option that best describes how you have felt and conducted yourself over the past 6 months.

1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?	☐ never	☐ rarely	☐ sometimes	☐ often	☐ very often
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?	☐ never	☐ rarely	☐ sometimes	☐ often	☐ very often
3. How often do you have problems remembering appointments or obligations?	☐ never	☐ rarely	☐ sometimes	☐ often	☐ very often
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	☐ never	☐ rarely	☐ sometimes	☐ often	☐ very often
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?	☐ never	☐ rarely	☐ sometimes	☐ often	☐ very often
6. How often do you feel overly active and compelled to do things like you were driven by a motor?	☐ never	☐ rarely	☐ sometimes	☐ often	☐ very often

SAINT LOUIS
SPORTS MEDICINE

Student-Athlete Name _____

25. HEALTH HISTORY

☐ YES ☐ NO Have you had an injury in the last year that has caused you to miss 3 or more consecutive days of practice/competition?
☐ YES ☐ NO Have you ever had any injury or illness other than those already noted?
☐ YES ☐ NO Do you have any ongoing or chronic illnesses?
☐ YES ☐ NO Do you have only one of any paired organs (eyes, kidneys, testicles, ovaries)?
☐ YES ☐ NO Have you ever been hospitalized overnight?
☐ YES ☐ NO Have you ever been told by a physician to restrict your sports activity or not to participate in a sport?
☐ YES ☐ NO Are you currently under a physician's care for any medical conditions?
☐ YES ☐ NO Have you ever been diagnosed or are you currently under physician care for ADHD or ADD?
☐ YES ☐ NO Are you currently taking any medications to treat ADHD or ADD?
☐ YES ☐ NO Have you consulted and/or been under the care of a chiropractor, hypnotist, acupuncturist, massage therapist, spiritual healer, and/or other such practitioner in the past five (5) years? (Circle all that apply.)
☐ YES ☐ NO Have you had a viral infection (i.e. mononucleosis, myocarditis, etc.) within the past six (6) months?
☐ YES ☐ NO Have you ever had seizures, convulsions, and/or epilepsy?
☐ YES ☐ NO Do you have frequent, severe (migraine) headaches?
☐ YES ☐ NO Do you have ringing in your ears or trouble hearing?
☐ YES ☐ NO Have you ever had an abnormal chest x-ray and/or pneumonia?
☐ YES ☐ NO Do you require any special equipment (braces, dental, orthotics, hearing aids, etc.)?_____
☐ YES ☐ NO Have you ever had the chickenpox? If yes, when? _____
☐ YES ☐ NO Have you had a tetanus booster within the past five (5) years? If yes, when? _____
☐ YES ☐ NO Have you ever received the Hepatitis B (HBV) Vaccination series (all 3 shots)? If yes, when? _____
☐ YES ☐ NO I have tried cigarettes, chewing tobacco, snuff, or dip.
☐ YES ☐ NO In the past 30 days, I have used chewing tobacco, snuff, or dip.
☐ YES ☐ NO Do you have any questions regarding drugs, tobacco, or alcohol?
☐ YES ☐ NO Have you had a weight change (loss or gain) of greater than 10 pounds in the past year?
☐ YES ☐ NO Are you a vegetarian or on a gluten-free diet? If yes, what type?_____
☐ YES ☐ NO Have you had a history of anorexia, bulimia (forced vomiting), and/or any other eating disorders?
☐ YES ☐ NO Would you like to meet with a dietitian to discuss your nutritional needs or eating habits?
☐ YES ☐ NO I have taken performance enhancing substances (including anabolic steroids).
☐ YES ☐ NO Are you aware of any reasons why you should not participate in intercollegiate athletics at Saint Louis University at this time?_____
☐ YES ☐ NO Would you like to see the team physician in private, for any reason? (You will not be asked to explain.)

Please explain all "yes" answers:

_____

_____

_____

_____

_____

_____

_____

SAINT LOUIS
SPORTS MEDICINE

Student-Athlete Name _____

CONSENT FOR TREATMENT & RELEASE OF MEDICAL INFORMATION

I hereby authorize the members of the Saint Louis University sports medicine department, its physicians and designees to treat any injury or illness that affects my ability to participate in athletic activities at Saint Louis University. I consent to the release of my medical records and related information to Saint Louis University personnel for use in connection with diagnosis, treatment, and/or rehabilitation of such injuries or illness and for determinations of fitness to return to play. This authorization shall expire at the end of the current academic year and/or the end of competitive season, whichever should come later in time.

I verify that all the information is accurate and complete. I understand that failure to disclose previous medical conditions may result in a medical disqualification. I understand that Saint Louis University is not responsible for expenses related to any previously existing conditions.

_____ _____

STUDENT-ATHLETE SIGNATURE / ELECTRONIC SIGNATURE (Please type your first and last name) DATE

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

_____

PRINT NAME

IF UNDER 18 YEARS OF AGE:

_____ _____

PARENT/GUARDIAN SIGNATURE / ELECTRONIC SIGNATURE (Please type your first and last name) DATE

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

_____

PRINT NAME

PARENTAL CONSENT

The law requires, with certain exceptions, that parental permission be obtained for operative and therapeutic procedures on minors. The following consent form must be signed by the parent or legal guardian, so that medical or emergency procedures can be carried out promptly, reducing unnecessary delay and discomfort. I give my permission for such medical procedures as may be deemed necessary for my son/daughter.

_____ _____

NAME OF STUDENT DATE

_____ _____

PARENT/GUARDIAN SIGNATURE / ELECTRONIC SIGNATURE (Please type your first and last name) RELATIONSHIP TO STUDENT

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

_____ _____

PHONE (HOME) PHONE (WORK/CELL)

_____ _____

ATHLETIC TRAINER SIGNATURE DATE

SAINT LOUIS
SPORTS MEDICINE

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

Student-Athlete Name _____
First Middle Initial Last

Date of Birth _____ Age _____ Student ID# _____ Sport _____

1. I hereby acknowledge that I received a copy of the Saint Louis University Notice of Privacy Practices.

_____ _____
STUDENT-ATHLETE SIGNATURE / ELECTRONIC SIGNATURE (Please type your first and last name) DATE

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

2. I hereby grant permission to the Sports Medicine Staff of Saint Louis University Department of Athletics to release health information pertaining to my fitness to participate in SLU Intercollegiate Athletic activities to Athletic Department administrators, coaches, and administrative staff responsible for assessing or approving my participation to the extent the information is needed for that purpose.

_____ _____
STUDENT-ATHLETE SIGNATURE / ELECTRONIC SIGNATURE (Please type your first and last name) DATE

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

3. I hereby grant permission to SLU Department of Athletics administrators and coaches to release to the news media the nature of any athletic-related injury or illness and my expected rehabilitation period, if any, for purposes of addressing my participation in intercollegiate athletic activities. This information may also be released to my parent or guardian.

_____ _____
STUDENT-ATHLETE SIGNATURE / ELECTRONIC SIGNATURE (Please type your first and last name) DATE

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

4. I understand that I have a right to revoke this authorization at any time. My revocation must be in writing in a letter provided to the Director of Athletics. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my Protected Health Information have acted in reliance upon this authorization. I understand that I do not have to sign this authorization and that SLU Department of Athletics may not condition treatment, payment, enrollment or eligibility for benefits on whether I sign this authorization. I further understand that if the persons(s) or organization(s) authorized to receive the information is not a health plan or health care provider, the released information may be re-disclosed and would no longer be protected by federal privacy regulations.

   I agree that a copy of this release or fax of this release shall be as valid as this original release. If I authorize SLU to fax the information, I realize there are inherent risks in faxing Protected Health Information. I understand a fee will be charged to cover the costs of copying, including the cost of supplies and labor of copying and mailing Protected Health Information released to anyone other than another health care provider. I understand I will get a copy of this form after I sign it.

_____ _____
STUDENT-ATHLETE SIGNATURE / ELECTRONIC SIGNATURE (Please type your first and last name) DATE

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

EACH AUTHORIZATION EXPIRES ONE CALENDAR YEAR FROM SIGNATURE DATE.

SAINT LOUIS
SPORTS MEDICINE

SAINT LOUIS UNIVERSITY SICKLE CELL POSITION STATEMENT

PURPOSE

On June 25, 2009 the NCAA Committee on Competitive Safeguards and Medical Aspects of Sports adopted the recommendation that member colleges and universities test student-athletes to confirm their Sickle Cell Trait status if that information is not already known.

Effective August 1, 2010, the NCAA is mandating under rule that all student-athletes must be tested. The NCAA mandatory medical examination rule states: "… a first time participant shall be required to undergo a medical examination or evaluation administered or supervised by a physician (e.g. family physician, team physician). The examination or evaluation shall include a sickle cell solubility test (SST), unless documented results of a prior test are provided to the institution. To specify the student-athlete is required a medical examination or evaluation that student-athletes who are beginning their initial season of eligibility and students who are trying out for a team must undergo prior to participation in voluntary summer conditioning or voluntary individual workouts pursuant to the safety exception, practice, competition or out of season conditioning activities shall include a Sickle Cell Solubility Test (SST), unless documented results of a prior test are provided to the institution". The examination or evaluation must have been administered within six months prior to participation.

In accordance with NCAA regulations, Saint Louis University Department of Athletics is mandating that all student-athletes must be tested for sickle cell trait or show proof of a prior test. Per NCAA rules Sickle Cell Testing waivers can no longer be accepted.

ABOUT SICKLE CELL DISEASE

Sickle cell disease is a term used for a group of conditions in which the pathology is due to the presence of hemoglobin S. Sickle cell anemia, or homozygous sickle cell disease, results from the inheritance of a sickle cell gene from both parents. Sickle cell disease is characterized by continuous red blood cell hemolysis usually resulting in anemia. This varies from patient to patient from inconsequential to severe; causing the variable presentation of painful vaso-occlusive crises; the potential for serious infections and acute complications involving any of the major organ systems, with progressive, irreversible organ damage. In sickle cell trait (the carrier state) there is always more normal (A) hemoglobin than S hemoglobin. Patients with sickle cell trait do not have symptoms from their sickle hemoglobin except under extraordinary conditions.

Eighty-five percent of people born with the disease now live to age 20, and most patients now survive at least until middle age. Patients are usually able to complete high school; many go on to college and graduate school; and all have the potential to lead productive lives. This greatly improved prognosis over the past generation is the result of comprehensive health maintenance, and the immediate treatment of acute complications, in combination with several therapeutic advances. Each patient with sickle cell disease needs a satisfactory "medical home" tailored to his or her individual needs.

- Sickle cell trait is an inherited disorder that affects red blood cells.
- Sickle cell trait is different from sickle cell disease, (commonly referred to as sickle cell anemia) and carriers of the trait cannot develop sickle cell disease.
- Usually, people with sickle cell trait do not have any medical problems and they can lead normal lives. However, sickle cell trait can change the shape of red blood cells during intense or extensive exertion, causing a blockage in blood vessels and rapid breakdown of muscles, including the heart, which may lead to a collapse or even death.
- More information regarding sickle cell trait and the NCAA's recommendation for sickle cell trait testing can be found at the official website for the NCAA.

REQUIREMENTS FOR STUDENT-ATHLETES

Starting in 2010, all SLU student-athletes will be tested for Sickle Cell unless prior testing and results can be provided. Those student-athletes not wishing to be tested should submit prior test results before they can participate in any intercollegiate athletics event, including strength and conditioning sessions, practices or competitions.

The screening test can be performed at Saint Louis University or with the student-athlete's physician. If the initial screening test is positive for sickle cell, then a follow-up test can be performed to determine if it is Sickle Cell Disease or Sickle Cell Trait. Educational sessions around the topic of sickle cell and the precautions that need to be undertaken due to the serious nature of the condition will be required for those individuals who are sickle cell trait positive.

Student-athletes must send documented results of sickle cell trait testing to:

Jonathan Burch, ATC
Director of Sports Medicine
Saint Louis University
Chaifetz Arena – Sports Medicine
3330 Laclede Avenue
St. Louis, MO 63103
jburch7@slu.edu

SAINT LOUIS
SPORTS MEDICINE

STUDENT-ATHLETE SUPPLEMENT NOTIFICATION FORM

I, _____, acknowledge that I am currently taking, have taken (within the past 6 months) or plan to take the following ergogenic aids, creatine powder, amino acids, protein supplements or other similar substances, hereinafter referred to as "Supplements." (Use back of form if necessary).

NAME	DOSAGE	MAIN INGREDIENTS	COMMENTS

I understand and agree:

a. Saint Louis University Department of Athletics neither approves nor condones the use of Supplements.

b. Saint Louis University does its best to ensure that all supplements distributed comply with NCAA, A10 and IOC recommendations. However, I understand that I voluntarily consume these beverages and understand the risks associated with taking them.

c. I have been informed of the Saint Louis University Department of Athletics, A10, National Collegiate Athletic Association(NCAA) and USOC policies with regards to the use of Supplements and have had any questions about these policies answered.

d. The use of Supplements may result in serious harm to me, possible permanent injury to my health and even death.

e. I risk losing my eligibility to participate in intercollegiate athletics if I test positive for an NCAA banned substance.

f. I must list all Supplements of the chain of custody forms at the time of any drug test.

I fully accept any and all risks and liability if I have used in the past, continue to use, or use at any time in the future any form of Supplements.

I further understand and agree Saint Louis University, its officers, employees, and agents are not responsible for any harm and possible permanent injury to my health caused by my past, present, or future use of Supplements. I agree to hold harmless, indemnify and irrevocably release, Saint Louis University, and its officers, employees, and agents from any and all liability, and demands claims and causes of action relating to my use of Supplements.

I understand the statements in this form and have had all questions about the information in this form answered to my satisfaction.

_____ _____

STUDENT-ATHLETE SIGNATURE / ELECTRONIC SIGNATURE (Please type your first and last name) DATE

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms of Acceptance.

SAINT LOUIS
SPORTS MEDICINE

Dear Parents/Guardians of Saint Louis University student-athletes,

It is within NCAA policy to randomly drug test student-athletes of NCAA member institutions for banned substances. For more information and a current list of NCAA banned substances please visit their website at http://www.ncaa.org/drugtesting. Specifically under this NCAA policy, medications used in the treatment of ADHD are banned. Under NCAA policy, it is a one year ban from athletics when a student-athlete tests positive for a banned stimulant. In order to remain compliant to the NCAA rules, this letter will serve as an outline to help us through this process.

1. If your son/daughter has not been diagnosed with ADHD, then no further action is needed.
2. If your son/daughter has been diagnosed with ADHD but is not taking medication, then no further action is needed. However, if medication for treatment becomes an option, then notify the Sports Medicine Department immediately. You will need to follow the instructions listed in the ADHD-ADD notification document.
3. If you son/daughter becomes diagnosed with ADHD then notify the Sports Medicine Department immediately. Consult the instructions listed in the ADHD-ADD notification document.
4. If your son/daughter has been diagnosed and on medication, then please follow the instructions listed in the ADHD-ADD notification document.
5. If your son/daughter is a returning student-athlete and currently under treatment (medication) for ADHD and all of the steps below previously (documentation is on file in Sports Medicine) is completed then you will need to have the treating physician complete the returning student-athlete ADHD medical form.

For those that fall into the category seeking a medical exception for the use of banned medications, the student-athlete must have all of the required information on file in the Sports Medicine Department before September 1.

I am attaching extremely important information, so please read through it very carefully. It will be the responsibility of the student-athletes to gather all of the requested information and forward that to me. Please feel free to call (314-977-3295) or e-mail Jburch7@slu.edu with any questions or concerns.

On behalf of the entire SLU Sports Medicine team, we look forward to the upcoming athletic year. We would like to welcome the incoming freshmen/transfer student-athlete. We hope for a healthy year for all of our student-athletes. Thank you for your time and attention in this matter.

Sincerely,

Jonathan Burch, ATC
Director of Sports Medicine
Saint Louis University
Chaifetz Arena – Sports Medicine
3330 Laclede Avenue
St. Louis, MO 63103
Phone – (314) 977-3295
Fax – (314) 977-3183

SAINT LOUIS
SPORTS MEDICINE

NCAA GUIDELINES TO DOCUMENT ADHD / ADD TREATMENT WITH BANNED STIMULANT MEDICATIONS

In August 2009, the National Collegiate Athletic Association (NCAA) implemented a stricter application of the NCAA Medical Exception policy, specifically for the use of the banned stimulant medications to treat Attention Deficit Hyperactivity Disorder (ADHD). In order to apply for a medical exception for the use of ADHD medications, student-athletes are required to submit additional information regarding their medication use and assessments.

The student-athlete's documentation from the prescribing physician to the Saint Louis University Sports Medicine staff should contain a minimum of the following information to help ensure that ADHD has been diagnosed and is being managed appropriately (see attachment for physician's letter criteria):

A. Description of the evaluation process which identifies the assessment tools and procedures.

B. Statement of the diagnosis including confirmation date.

C. History of ADHD treatment (previous/ongoing).

D. Statement that a non-banned ADHD alternative medication has been considered if a stimulant is currently prescribed.

E. Statement regarding physician follow-up and monitoring visits.

ADHD – Attention Deficit/Hyperactivity Disorder is one of the most common neurobehavioral disorders of childhood and can persist through adolescence and into adulthood. ADHD is generally diagnosed in childhood, but sometimes not until college or later. The most common medications used to treat ADHD are methylphenidate (Ritalin) and amphetamine (Adderall), which are banned under NCAA class of stimulants.

NCAA MEDICAL EXCEPTIONS – The NCAA list of banned drug classes is composed of substances that are generally reported to be performance enhancing. The NCAA bans performance enhancing drugs to protect student-athlete health and safety. The NCAA recognizes that some of these substances may be legitimately used as medications to treat student-athletes with learning disabilities and other medical conditions.

Accordingly, the NCAA allows exceptions to be made for those student-athletes with a documented medical history demonstrating the need for regular use of such a drug. The benefit of a medical exception procedure is that in most cases the student-athlete's eligibility remains intact during the process.

In order for a medical exception to be granted for the use of these stimulant medications, the student-athlete must show that he or she had undergone standard assessment to identify ADHD. Frequently a student-athlete may find that the demands of college present difficult learning challenges. They may realize that some of their class/teammates benefit from the use of these medications and consult a physician to prescribe the same for them. **If they do not undergo a standard assessment to diagnose ADHD, they have not met the requirements for an NCAA medical exception.**

Most universities provide these types of assessment through their student support services or counseling/testing centers. The student-athlete should either provide documentation of an earlier assessment or undergo an assessment prior to using the stimulant medication for ADHD.

In order for a student-athlete to be granted a medical exception for the use of a medication that contains a banned substance, the student-athlete must have:

- Declared the use of the substance to his or her Certified Athletic Trainer or athletics administrator (Head Athletic Trainer) responsible for keeping medical records.
- Present documentation of the diagnosis of the condition.
- Provide documentation from the prescribing physician explaining the course of treatment and current prescription.
- Annual completion of a medical form by the treating physician for returning student-athletes on file.

Requests for medical exceptions will be reviewed by physicians who are members of the NCAA Committee on Competitive Safeguards and Medical Aspects of Sports. Medical exceptions will be granted if the student-athlete has presented adequate documentation as noted.

SAINT LOUIS
SPORTS MEDICINE

STUDENT-ATHLETE DOCUMENT RESPONSIBILITY

Criteria for letter from prescribing Physician to provide documentation to the Saint Louis University Sports Medicine Department regarding assessment of student-athletes taking prescribed stimulants for Attention Deficit Disorder (ADHD), in support of an NCAA Medical Exception request for the use of a banned substance.

The following must be included in supporting documentation:

- Student-athlete name
- Student-athlete date of birth
- Date of clinical evaluation

Clinical evaluation components including:

- Summary of comprehensive clinical evaluation (referencing DSM-V criteria) – attach supporting documentation.
- ADHD Rating Scale(s) (i.e. Connors, ASRS, CAARS) scores and report summary – attach supporting documentation.
- Blood pressure and pulse readings and comments.
- Note that alternative non-banned medications have been considered and comments.
- Diagnosis.
- Medication(s) and dosage.
- Follow-up orders.

Additional ADHD evaluation components if available:

- Report ADHD symptoms by other significant individual(s).
- Psychological testing results.
- Physical exam date and results.
- Laboratory/testing results.
- Summary of previous ADHD diagnosis.
- Other comments.

Documentation from prescribing physician must also include the following:

- Physician name (Printed).
- Office addresses and contact information.
- Specialty.
- Physician signature and date.

SAINT LOUIS
SPORTS MEDICINE

Dear Healthcare Provider,

Your patient, a student-athlete at Saint Louis University, plans to, or already participates in intercollegiate athletics at our institution. The National Collegiate Athletic Association (NCAA) 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 banned for use by NCAA student-athletes unless medical necessity is clearly documented by the host university. The Saint Louis University Sports Medicine Department / Department of Athletics are requesting the following information in order for the student-athlete to continue or begin their NCAA participation. This is required for their 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 their treatment. In completing this documentation, you acknowledge that you have reviewed the patient's health history and have informed them of the safety information regarding stimulant use as well as misuse guidelines. Please attach any consult letters or SOAP notes that may clarify their diagnosis and the need to use stimulant medications for treatment.

Thank you for taking the time to do this. We greatly appreciate your assistance as we all try to comply with NCAA requirements.

Sincerely,

Jonathan Burch, ATC
Director of Sports Medicine
Saint Louis University Sports Medicine Department

Please send documentation to:
Saint Louis University – Athletics
Chaifetz Arena
Attn: Director of Sports Medicine
3330 Laclede Avenue
St. Louis, MO 63103
Phone – (314) 977-3295
Fax – (314) 977-3183

SAINT LOUIS
SPORTS MEDICINE

MEDICAL EXCEPTION ADHD/ADD

Student-Athlete Name _____ Date of Birth _____ Banner ID # _____

Physician (Name) _____ Specialty _____

Physician Address _____ Telephone Number _____

_____ is under my care for treatment of ADHD/ADD since _____
Patient's Name Date of initial treatment

☐ YES ☐ NO Alternative non-stimulant medication use has been considered, or tried, with unsatisfactory clinical results: LIST those tried, if applicable: _____

The current medication and dosage is: _____

Reason for this medication: _____

_____

☐ YES ☐ NO The student-athlete has undergone formal psychological/neuropsychological testing confirming the diagnosis of ADHD or ADD. List "None" if no formal testing done.

Name and title of the provider who conducted the formal psychological evaluation:

_____

☐ YES ☐ NO An accepted ADHD rating scale was used to make the diagnosis.
If NO how was the course of treatment determined? (Attach any clinical SOAP notes)

☐ YES ☐ NO CONNER'S Adult ADHD reporting scales (CAARS)

☐ YES ☐ NO ASRS (Adult ADHD self report scale)

Other: _____

Physician Signature _____ Date _____

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

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

3 months 6 months 12 months _____ (months) no planned follow up

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. **THANK YOU FOR YOUR TIME.**

I,_____ , give Saint Louis University permission to release all information regarding my treatment for ADHD to the National Collegiate Athletic Association Medical Exception Committee (for banned substances). 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 Sports Medicine, with the 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 _____ Date _____

SAINT LOUIS
SPORTS MEDICINE

ADHD STUDENT-ATHLETE ANNUAL MEDICAL FORM

Please complete this medical form for Saint Louis University Student-athletes who have completed initial documentation needed for a NCAA medical exemption for use of a NCAA banned medication. This form serves as the annual update. All previous medical documentation needed is currently on file with the SLU Sports Medicine Department.

Student-Athlete Name _____ Date of Birth _____ Banner ID # _____

Physician (Name) _____ Specialty _____

Physician Address _____ Telephone Number _____

_____ is under my care for treatment of ADHD/ADD since _____
Patient's Name Date of initial treatment

Physician Signature _____ Date _____

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

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

3 months 6 months 12 months _____ (months) no planned follow up

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. THANK YOU FOR YOUR TIME!

I,_____ , give Saint Louis University permission to release all information regarding my treatment for ADHD to the National Collegiate Athletic Association Medical Exception Committee (for banned substances). 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 Sports Medicine, with the 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 _____ Date _____

SAINT LOUIS
SPORTS MEDICINE

CONCUSSION MANAGEMENT PLAN

Concussion is a common consequence of collisions, falls and other forms of contact in sports. Concussion is defined as a traumatically induced transient disturbance of brain function, which is generally self-limited. Signs and symptoms of concussive injury vary. These symptoms may include headache, dizziness, nausea, poor concentration and increased sensitivity to light. Studies report 80-90% of athletes has symptom resolution within 7 - 10 days of their injury, although symptom resolution may not correlate with return to normal brain function. Concussion may be complicated by continuation of symptoms (the post-concussive syndrome) and in rare cases by cerebral edema related to the second impact syndrome. The risk for prolonged recovery is increased in athletes who prematurely return to play.

It is the role of the team physician to evaluate the concussed athlete, develop a management plan to expedite their recovery from injury, and determine appropriate return to play timing. Existing guidelines clearly state that an athlete should not be given same day return to play clearance if a concussion is suspected, and should not be allowed to resume sports participation until all symptoms of a concussion have resolved.

The importance of rapidly identifying those athletes who have suffered a concussive injury is well established in order to prevent prolonged symptoms and worsened outcomes. A growing body of research exists to assist the team physician in management and return to play decisions following such an injury. Two expert panel (Zurich 2012 and AMSSM Position Statements) guidelines together form Saint Louis University (SLU) “standards of care” for concussive injury.

This Management Plan has been developed to protect our student-athletes during their time at SLU. It is also a mandatory component of any athletics program, as outlined in the NCAA handbook: “Institutions shall have a concussion management plan on file such that a student- athlete who exhibits signs symptoms or behaviors consistent with a concussion shall be removed from practice or competition and be evaluated by an athletics healthcare provider with experience in the evaluation and management of concussion. Student-athletes diagnosed with a concussion shall not return to activity for the remainder of that day. Medical clearance shall be determined by the team physician or their designee according to the concussion management plan.”

DEFINITIONS AND DIAGNOSIS

A concussion is a traumatically induced, transient disturbance in brain function, which is usually self-limited. It may be caused by a direct blow to the head or a force indirectly transferred to the head. Signs and symptoms of a concussion are varied. The most common symptoms are headache and dizziness. Other non-specific symptoms include confusion, amnesia, difficulty concentrating, sleep disturbances, increased sensitivity to light and sometimes depression or anxiety. Less than 10% of concussions involve loss of consciousness. Symptoms of a concussion may immediately follow the head trauma or evolve gradually over several minutes to hours. These symptoms, outlined above, are usually transient and resolve over a short period of time. Occasionally there can be a more severe injury; thus it is important that concussed individuals be monitored.

CONCUSSION

A FACT SHEET FOR STUDENT-ATHLETES

WHAT IS A CONCUSSION?

A concussion is a brain injury that:

- Is caused by a blow to the head or body.
  - From contact with another player, hitting a hard surface such as the ground, ice or floor, or being hit by a piece of equipment such as a bat, lacrosse stick or field hockey ball.
- Can change the way your brain normally works.
- Can range from mild to severe.
- Presents itself differently for each athlete.
- Can occur during practice or competition in ANY sport.
- **Can happen even if you do not lose consciousness.**

HOW CAN I PREVENT A CONCUSSION?

Basic steps you can take to protect yourself from concussion:

- Do not initiate contact with your head or helmet. You can still get a concussion if you are wearing a helmet.
- Avoid striking an opponent in the head. Undercutting, flying elbows, stepping on a head, checking an unprotected opponent, and sticks to the head all cause concussions.
- Follow your athletics department's rules for safety and the rules of the sport.
- Practice good sportsmanship at all times.
- Practice and perfect the skills of the sport.

WHAT ARE THE SYMPTOMS OF A CONCUSSION?

You can't see a concussion, but you might notice some of the symptoms right away. Other symptoms can show up hours or days after the injury. Concussion symptoms include:

- Amnesia.
- Confusion.
- Headache.
- Loss of consciousness.
- Balance problems or dizziness.
- Double or fuzzy vision.
- Sensitivity to light or noise.
- Nausea (feeling that you might vomit).
- Feeling sluggish, foggy or groggy.
- Feeling unusually irritable.
- Concentration or memory problems (forgetting game plays, facts, meeting times).
- Slowed reaction time.

Exercise or activities that involve a lot of concentration, such as studying, working on the computer, or playing video games may cause concussion symptoms (such as headache or tiredness) to reappear or get worse.

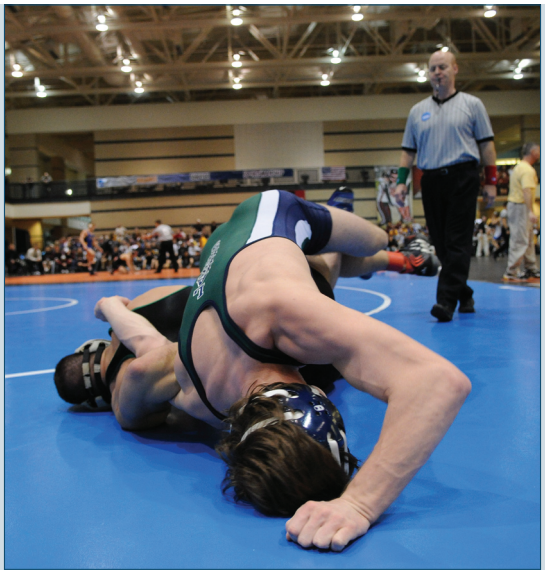
WHAT SHOULD I DO IF I THINK I HAVE A CONCUSSION?

Don't hide it. Tell your athletic trainer and coach**.** Never ignore a blow to the head. Also, tell your athletic trainer and coach if one of your teammates might have a concussion. Sports have injury timeouts and player substitutions so that you can get checked out.

Report it. Do not return to participation in a game, practice or other activity with symptoms. The sooner you get checked out, the sooner you may be able to return to play.

Get checked out. Your team physician, athletic trainer, or health care professional can tell you if you have had a concussion and when you are cleared to return to play. A concussion can affect your ability to perform everyday activities, your reaction time, balance, sleep and classroom performance.

Take time to recover. If you have had a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have a repeat concussion. In rare cases, repeat concussions can cause permanent brain damage, and even death. Severe brain injury can change your whole life.



IT'S BETTER TO MISS ONE GAME THAN THE WHOLE SEASON. WHEN IN DOUBT, GET CHECKED OUT.

For more information and resources, visit www.NCAA.org/health-safety and www.CDC.gov/Concussion.