

REMINDER: LATE SUBMISSION PENALTIES

SPORTS PHYSICAL FORMS THAT ARE SUBMITTED AFTER THE DUE DATE WILL BE SUBJECT TO THE FOLLOWING CONSEQUENCES:

ONE WEEK LATE: ATHELETE WILL NOT BE ALLOWED TO PARTICIPATE IN HIS/HER SPORT FOR 1 DAY AFTER HE/SHE HAS BEEN CLEARED TO PARTICIPATE.

TWO WEEKS LATE: ATHELETE WILL NOT BE ALLOWED TO PARTICIPATE IN HIS/HER SPORT FOR 2 DAYS AFTER HE/SHE HAS BEEN CLEARED TO PARTICIPATE.

THREE WEEKS LATE: ATHELETE WILL NOT BE ALLOWED TO PARTICIPATE IN HIS/HER SPORT FOR 1 WEEK AFTER HE/SHE HAS BEEN CLEARED TO PARTICIPATE.

FOUR WEEKS OR LONGER LATE: ATHELETE WILL NOT BE ALLOWED TO PARTICIPATE IN HIS/HER SPORT FOR 2 WEEKS AFTER HE/SHE HAS BEEN CLEARED TO PARTICIPATE.

PLEASE NOTE:

THE SCHOOL PHYSICIAN HAS BEEN CONTRACTED BY OUR BOARD OF EDUCATION TO VISIT OUR SCHOOL 3 TIMES PER PRE

SEASON.

THE SOLE PURPOSE FOR EACH OF THESE VISITS IS TO REVIEW AND SIGN OFF NEW SPORTS PHYSICALS. THIS DOES NOT INCLUDE ALREADY EXISTING VALID SPORTS PHYSICALS ON FILE IN THE HEALTH OFFICE.

THESE 3 VISITS GENERALLY FALL WITHIN THE 4 WEEK TIME FRAME OF THE STATED DUE DATES. THEREFORE, **IF NEW PHYSICAL FORMS ARE TURNED IN LATER THAN THE LAST CONTRACTUAL VISIT MADE BY OUR SCHOOL PHYSICIAN, IT WILL BE THE ATHLETE'S RESPONSIBILITY TO INCUR ANY ADDITIONAL COSTS** SHOULD ANOTHER VISIT BY THE SCHOOL PHYSICIAN BE REQUIRED TO CLEAR THOSE FORMS SUBMITTED AFTER THE DEADLINE.

**ROXBURY PUBLIC SCHOOLS
SCHOOL PHYSICIAN'S NOTIFICATION OF SPORTS PARTICIPATION**

To the Parent/Guardian of _____ Grade _____ Sport _____

The above named student

1. May participate with no restrictions
2. May participate with the following restrictions

CLASSIFICATION OF SPORTS BY CONTACT			
		NON-CONTACT	
<input type="checkbox"/> <u>Collision/Contact</u>	<input type="checkbox"/> <u>Limited Contact</u>	<input type="checkbox"/> <u>Strenuous</u>	<input type="checkbox"/> <u>Non Strenuous</u>
Field Hockey	Baseball	Field	Bowling
Football	Basketball	Discus	Golf
Ice Hockey	Diving	Javelin	
Lacrosse	Fencing	Shot put	
Soccer	Field	Rowing	
Wrestling	High Jump	Running/Cross Country	
	Pole Vault	Swimming	
	Gymnastics	Tennis	
	Skiing	Track	
	Softball		
	Volleyball		

3. Conditions requiring special consideration before clearance of sports participation

<ul style="list-style-type: none"> • Atlantoaxial Instability • Hypertension • Dysrhythmia • Heart Murmur • Diabetes Mellitus • Heat Illness History • Hepatomegaly, Splenomegaly • History of repeated concussion • Cystic Fibrosis • One-eyed Athletes or Athletes with vision > 20/40 in one eye 	<ul style="list-style-type: none"> • Bleeding Disorder • Congenital Heart Disease • Mitral Valve Prolapse • Cerebral Palsy • Eating Disorders • One-kidney Athletes • Malignancy • Organ Transplant Recipient • Sickle Cell Disease
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4. Other _____

Notification regarding this student's participation in athletics is based solely on the medical examination and results submitted by the examining physician, nurse practitioner, or physician's assistant from the student's medical home. The medical report complies with the requirements of NJAC6A:16-2.2.

Notification regarding this student's participation in athletics is based solely on the Athletic Participation Health History Update submitted and signed by the student's parent/guardian.

Explanation _____

School Physician's Initials/Stamp: _____ Date _____

New Jersey Department of Education ANNUAL ATHLETIC PRE-PARTICIPATION PHYSICAL EXAMINATION FORM

Part A: HEALTH HISTORY QUESTIONNAIRE-Completed by the parent and student and reviewed by examining provider
Part B: PHYSICAL EVALUATION FORM-Completed by examining licensed provider with MD, DO, APN or PA

Part A: HEALTH HISTORY QUESTIONNAIRE

Today's Date: _____ Date of Last Sports Physical: _____

Student's Name: _____ Sex: M F (circle one) Age: ____ Grade: ____
 Date of Birth: ____/____/____ School: _____ District: _____
 Sport(s): _____ Home Phone: (____) _____
 Provider Name (Medical Home): _____ Phone: _____ Fax: _____

EMERGENCY CONTACT INFORMATION

Name of parent/guardian: _____ Relationship to student: _____
 Phone (work): _____ Phone (home): _____ Phone (cell): _____
 Additional emergency contact: _____ Relationship to student: _____
 Phone (work): _____ Phone (home): _____ Phone (cell): _____

Directions: Please answer the following questions about the student's medical history by **CIRCLING** the correct response. Explain all "yes" responses on the lines below the questions. Please respond to all questions.

- 1. Have you ever had, or do you currently have:**
- a. Restriction from sports for a health related problem? Y / N / Don't Know
 - b. An injury or illness since your last exam? Y / N / Don't Know
 - c. A chronic or ongoing illness (such as diabetes or asthma)? Y / N / Don't Know
 - (1.) An inhaler or other prescription medicine to control asthma? Y / N / Don't Know
 - d. Any prescribed or over the counter medications that you take on a regular basis? Y / N / Don't Know
 - e. Surgery, hospitalization or any emergency room visit(s)? Y / N / Don't Know
 - f. Any **allergies** to medications? **Y / N / Don't Know**
 - g. Any allergies to bee stings, pollen, latex or foods? Y / N / Don't Know
 - (1.) If yes, check type of reaction:
 - Rash Hives Breathing or other anaphylactic reaction
 - (2.) Take any medication/Epipen taken for allergy symptoms? (List below.) Y / N / Don't Know
 - h. Any anemias, blood disorders, sickle cell disease/trait, bleeding tendencies or clotting disorders? Y / N / Don't Know
 - i. A blood relative who died before age 50? Y / N / Don't Know

Explain all "yes" answers here (include relevant dates):

List all medications here:

Medication Name	Dosage	Frequency

2. **Have you ever had, or do you currently have, any of the following *head-related* conditions:**

- | | |
|---|--------------------|
| a. Concussion or head injury (including "bell rung" or a "ding")? | Y / N / Don't Know |
| b. Memory loss? | Y / N / Don't Know |
| c. Knocked out? | Y / N / Don't Know |
| c. A seizure? | Y / N / Don't Know |
| d. Frequent or severe headaches (With or without exercise)? | Y / N / Don't Know |
| e. Fuzzy or blurry vision | Y / N / Don't Know |
| f. Sensitivity to light/noise | Y / N / Don't Know |

Explain all "yes" answers here (include relevant dates):

3. **Have you ever had, or do you currently have, any of the following *heart-related* conditions:**

- | | |
|--|--------------------|
| a. Restriction from sports for heart problems? | Y / N / Don't Know |
| b. Chest pain or discomfort? | Y / N / Don't Know |
| c. Heart murmur? | Y / N / Don't Know |
| d. High blood pressure? | Y / N / Don't Know |
| e. Elevated cholesterol level? | Y / N / Don't Know |
| f. Heart infection? | Y / N / Don't Know |
| g. Dizziness or passing out during or after exercise without known cause? | Y / N / Don't Know |
| h. Has a provider ever ordered a heart test (EKG, echocardiogram, stress test, Holter monitor)? | Y / N / Don't Know |
| i. Racing or skipped heartbeats? | Y / N / Don't Know |
| j. Unexplained difficulty breathing or fatigue during exercise? | Y / N / Don't Know |
| k. Any family member (blood relative): | |
| (1.) Under age 50 with a heart condition? | Y / N / Don't Know |
| (2.) With Marfan Syndrome? | Y / N / Don't Know |
| (3.) Died of a heart problem before age 50? If yes, at what age? _____ | Y / N / Don't Know |
| (4.) Died with no known reason? | Y / N / Don't Know |
| (5.) Died while exercising? If yes, was it during or after? (Circle one.) | Y / N / Don't Know |

Explain all "yes" answers here (include relevant dates):

4. **Have you ever had, or do you currently have, any of the following *eye, ear, nose, mouth or throat* conditions:**

- | | |
|---|--------------------|
| a. Vision problems? | Y / N / Don't Know |
| (1.) Wear contacts, eyeglasses or protective eye wear? (Circle which type.) | Y / N / Don't Know |
| b. Hearing loss or problems? | Y / N / Don't Know |
| (1.) Wear hearing aides or implants? | Y / N / Don't Know |
| c. Nasal fractures or frequent nose bleeds? | Y / N / Don't Know |
| d. Wear braces, retainer or protective mouth gear? | Y / N / Don't Know |
| e. Frequent strep or any other conditions of the throat (e.g. tonsillitis)? | Y / N / Don't Know |

Explain all "yes" answers here (include relevant dates):

5. **Have you ever had, or do you currently have, any of the following *neuromuscular/orthopedic* conditions.**

- | | |
|---|--------------------|
| a. Numbness, a "burner", "stinger" or pinched nerve? | Y / N / Don't Know |
| b. A sprain? | Y / N / Don't Know |
| c. A strain? | Y / N / Don't Know |
| d. Swelling or pain in muscles, tendons, bones or joints? | Y / N / Don't Know |
| e. Dislocated joint(s)? | Y / N / Don't Know |
| f. Upper or lower back pain? | Y / N / Don't Know |
| g. Fracture(s), stress fracture(s), or broken bone(s)? | Y / N / Don't Know |
| h. Do you wear any protective braces or equipment? | Y / N / Don't Know |

Explain all (yes) answers here (include relevant dates):

6. Have you ever had or do you currently have any of the following *general or exercise related conditions*:

- | | |
|---|--------------------|
| a. Difficulty breathing? | |
| (1.) During exercise? | Y / N / Don't Know |
| (2.) After running one mile? | Y / N / Don't Know |
| (3.) Coughing, wheezing or shortness of breath in weather changes? | Y / N / Don't Know |
| (4.) Exercise-induced asthma? | Y / N / Don't Know |
| i. Controlled with medication? (specify _____) | Y / N / Don't Know |
| ii. Experience dizziness, passing out or fainting? | Y / N / Don't Know |
| b. Viral infections (e.g. mono, hepatitis, coxsackie virus)? | Y / N / Don't Know |
| c. Become tired more quickly than others? | Y / N / Don't Know |
| d. Any of the following skin conditions: | |
| (1.) Cold sores/herpes, impetigo, MRSA, ringworm, warts? | Y / N / Don't Know |
| (2.) Sun sensitivity? | Y / N / Don't Know |
| e. Weight gain/loss (of 10 pounds or more)? | Y / N / Don't Know |
| (1.) Do you want to weigh more or less than you do now? | Y / N / Don't Know |
| f. Ever had feelings of depression? | Y / N / Don't Know |
| g. Heat-related problems (dehydration, dizziness, fatigue, headache)? | Y / N / Don't Know |
| (1.) Heat exhaustion (cool, clammy, damp skin)? | Y / N / Don't Know |
| (2.) Heat stroke (hot, red, dry skin)? | Y / N / Don't Know |
| (3.) Muscle cramps? | Y / N / Don't Know |
| h. Absence or loss of an organ (e.g. kidney, eyeball, spleen, testicle, ovary)? | Y / N / Don't Know |

Explain all "yes" answers here (include relevant dates):

7. **Females only:**

Age of onset of menstruation: _____ How many menstrual periods in the last twelve (12) months? _____

How many periods missed in the last twelve (12) months? _____

8. **Males only:**

Have you had any swelling or pain in your testicles or groin? Y / N / Don't Know

PARENT/GUARDIAN SIGNATURE

I certify that the information provided herein is accurate to the best of my knowledge as of the date of my signature.

Signature, Parent/Guardian or Student Age 18

Date of Signature:

THIS COMPLETED AND SIGNED HEALTH HISTORY MUST BE REVIEWED BY THE EXAMINING PROVIDER AT THE TIME OF THE MEDICAL EXAM.

ANNUAL ATHLETIC PRE-PARTICIPATION PHYSICAL EVALUATION FORM

Part B: Physical Evaluation Form

(Completed by the examining licensed provider MD, DO, APN or PA)

-STUDENT INFORMATION-

Student's Name: _____ Sport(s): _____
 Sex: M F (circle one) Age: _____ Grade: _____ Date of Birth: _____
 Address: _____
 City/State/Zip: _____ Home Phone: _____
 School: _____ District: _____
 Parent/Guardian's Full Name: _____

- EXAMINING PHYSICIAN/PROVIDER CONTACT INFORMATION-

If conducted by school physician check here

Name: _____ Phone: _____ Fax: _____
 Address: _____ City/State/Zip: _____

- FINDINGS OF PHYSICAL EVALUATION -

Height: _____ Weight: _____ Blood Pressure: _____ / _____ Pulse: _____ bpm.
 Vision: R 20/____ L 20/____ Corrected: Y / N Contacts: Y / N Glasses: Y / N

INDICATORS	NORMAL?	ABNORMAL FINDINGS/COMMENTS
General Appearance	YES	
Head/Neck	YES	
Eyes/Sclera/Pupils	YES	
Ears	YES	
Gross Hearing	YES	
Nose/Mouth/Throat	YES	
Lymph Glands	YES	
Cardiovascular	YES	
Heart Rate	YES	
Rhythm	YES	
Murmur	ABSENT	
If murmur present		Standing makes it: Louder Softer No Change
		Squatting makes it: Louder Softer No Change
		Valsalva makes it: Louder Softer No Change
Femoral Pulses	YES	
Lungs: Auscultation/Percussion	YES	
Chest Contour	YES	
Skin	YES	
Abdomen (liver, spleen, masses)	YES	
Assessment of physical maturation or Tanner Scale	YES	
Testicular Exam (Males Only)	YES	
Neck/Back/Spine:	YES	
Range of Motion	YES	
Scoliosis	ABSENT	
Upper Extremities: (ROM, Strength, Stability)	YES	
Lower Extremities: (ROM, Strength, Stability)	YES	
Neurological: Balance & Coordination	YES	
Hernia	ABSENT	
Evidence of Marfan Syndrome	ABSENT	

Most recent immunizations and dates administered:

Medications currently prescribed, with dose and frequency:

Medication Name	Dosage	Frequency

Additional observations:

General Diagnosis:

General Recommendations:

THE HISTORY PREPARED BY THE PARENT/STUDENT MUST BE REVIEWED BY THE EXAMINING PROVIDER AT THE TIME OF THE PHYSICAL EXAMINATION.

CLEARANCES: This section is completed by the examining healthcare provider.

After examining the student and reviewing the medical history the student is:

- A. Cleared for participation in all sports without restrictions.
- B. Not cleared for participation in any sport until evaluation/treatment of:

- C. Cleared for limited participation in the following types of sports only. Please see below for sport classifications. CHECK ALL THAT APPLY

___ CONTACT/COLLISION
___ LIMITED CONTACT

___ NON-CONTACT/STRENUOUS
___ NON-CONTACT/NON-STRENUOUS

Limitations due to: _____

NOTES TO THE EXAMINING PROVIDER

Conditions requiring clearance before sports participation include, but are not limited to the following:

Anaphylaxis; Atlantoaxial instability; Bleeding disorder; Hypertension; Congenital heart disease; Dysrhythmia; Mitral valve prolapse; Heart murmur; Cerebral palsy; Diabetes mellitus; Eating disorders; Heat illness history; One-kidney athletes; Hepatomegaly; Splenomegaly; Malignancy; Seizure Disorder; Marfan's Syndrome; History of repeated concussion; Organ transplant recipient; Cystic fibrosis; Sickle cell disease; and/or One-eyed athletes or athletes with vision greater than 20/40 in one eye.

SAMPLES OF CLASSIFICATION OF SPORTS BY CONTACT

Contact/Collision	Limited Contact	Non-Contact	
		Strenuous	Non-strenuous
Basketball	Baseball	Discus	Bowling
Diving	Cheerleading	Javelin	Golf
Field Hockey	Fencing	Shot put	
Football	High Jump	Rowing	
Ice Hockey	Pole vault	Running/Cross Country	
Lacrosse	Gymnastics	Strength Training	
Soccer	Skiing	Swimming	
Wrestling	Softball	Tennis	
	Volleyball	Track	

Effects of physiologic maneuvers on heart sounds

Standing Increases murmur of HCM
Decreases murmur of AS, MR
MVP click occurs earlier in systole

Squatting Increases murmur of AS, MR, AI
Decreases murmur of MCH
MVP click delayed

Valsalva Increases murmur of HCM
Decreases murmur of AS, MR
MVP click occurs earlier in systole

Physical Stigmata of Marfan's Syndrome

Kyphosis
High arched palate
Pectus excavatum
Arachnodactyly
Arm span > height 1.05:1 or greater
Mitral Valve Prolapse
Aortic Insufficiency
Myopia
Lenticular dislocation

HCM: Hypertrophic Cardio Myopathy
AS: Aortic Stenosis
AI: Aortic Insufficiency
MR: Mitral Regugitation
MVP: Mitral Valve Prolapse

HISTORY REVIEWED AND STUDENT EXAMINED BY: Physician's/Provider's Stamp:

- Primary Care Provider
- School Physician Provider
- License Type:
 - MD/DO
 - APN
 - PA

PHYSICIAN'S/PROVIDER'S SIGNATURE: _____

Today's Date: _____

Date of Exam: _____

RESERVED FOR SCHOOL DISTRICT USE

NOTE: *N.J.A.C. 6A:16-2.2* requires the school physician to provide written notification to the parent/legal guardian stating approval or disapproval of the student's participation in athletics based on this physical evaluation. This evaluation and the notification letter become part of the student's school health record.

History and Physical Reviewed By: _____ Date: _____

Title of Reviewer (please check one): School Nurse School Physician

Medical Eligibility Notification Sent to Parent/Guardian by School Physician _____
Date

Letter of notification is attached.

OR

Parent notification indicates that:

- Participation Approved without limitations.
- Participation Approved with limitations pending evaluation.
- Participation NOT Approved

Reason(s) for Disapproval: _____

ROXBURY DISTRICT ATHLETIC EMERGENCY INFORMATION

Name _____ DOB _____ Age _____

Address _____

Athlete lives with (circle): both parents mother father guardian

Sport _____ Grade _____

Mother's Name _____ Home Phone _____

Cell _____ Work _____

Father _____ Home Phone _____

Cell _____ Work _____

Emergency Contacts:

Name _____ Home Phone _____

Cell _____ Work _____

Name _____ Home Phone _____

Cell _____ Work _____

Family Doctor _____ Phone _____

Dentist _____ Phone _____

Medical Insurance _____ Policy # _____

I give permission for my child's participation in the indicated sport for the 20____ season and to accompany the team on scheduled athletic trips. All athletes are covered by school insurance, which is an excess policy that can be used only after the family health insurance has been used. Please note that the rules of the New Jersey Board of Education require that the school district advise you, as a parent/guardian, of the possibility of physical hazards to your child.

I give permission to share medical information as needed with the appropriate personnel. I give our consent for coaches, trainers and the team physician to use their own judgments in the application of first aid treatment and in securing medical aid and ambulance service as necessary.

Your signature is acknowledgement of notification and approval to participate.

Parent/Guardian Signature Student Signature Date

+++++

(OFFICE USE ONLY)

PE Date _____ BP _____ P _____ Td _____

Asthma _____ Inhaler _____

Severe Allergies (type) _____ EpiPen _____

Medication Allergies _____

Chronic/Ongoing Medical Conditions _____

Cardiac Conditions _____

Orthopedic Conditions _____

History of Fracture/Sprain/Dislocation _____

Protective Equipment _____

Neurological Conditions/Concussion _____

Current Medications _____

Other _____

Glasses _____ Contacts _____ Dental: Braces _____ Retainer _____

AD Signature _____ RN Signature _____

Date _____ Date _____

Athletic Training Policies and Procedures

Dear Parent/Guardian:

In the unfortunate event that your son or daughter sustains an injury or illness (**which affects sport participation**), the following measures will ensure that he/she receives the best possible care.

1. Make sure that your son or daughter reports all injuries/illnesses to the athletic trainer. Contact will be made to the parent with regard to the proper treatment for the injury.
2. If the athlete sees a physician for **any reason** (i.e. sprained ankle, illness such as mononucleosis) **that would affect their sports participation** during the season, **he/she will be required to bring a clearance note from the physician's office. If a student sees a physician outside of the state of New Jersey, he/she must be cleared by a physician licensed in the state of New Jersey prior to returning to competition/practice**
 - The note must be signed by the physician, licensed in the state of New Jersey
 - State any restrictions
 - List a date that the athlete can safely return to activity.
 - **The athlete will not be allowed to return to activity until the ATHLETIC TRAINER, (NOT THE COACH) receives this note.**
 - School nurse must also get a copy of the note
3. Students must report to rehabilitation/treatment sessions on time (i.e. Lunch, study hall, prior/post-practice if scheduled ahead of time with the athletic trainer). **It is the athlete's responsibility to report to practice on time.**
4. Do not touch any equipment without prior approval from the athletic trainer.
5. All treatment/rehabilitation decisions will be made by the athletic trainer and/or by a supervising physician licensed in the state of New Jersey.
6. You will treat that athletic training staff with respect. They are here to help you.
7. Do not remove any equipment or supplies from the athletic training room.
8. If injured, you will be expected to report to the athletic training room **every day** for treatment/rehabilitation and subsequent evaluation of your progress unless told otherwise by the athletic trainer.
9. Athletic training room hours will vary depending on season and need. It is your responsibility to find out when the athletic training room will be open.
10. Any violations of the above rules/regulations will result in disciplinary action

I have completely read and fully understand the aforementioned procedures. I understand that if I do not follow these rules, I will be removed from participation until the matter is resolved.

Athlete's name: (PRINT) _____

Athlete's signature: _____

Date: _____

Parent/Guardian Signature: _____

Date: _____

NJSIAA



1161 Route 130, P.O. Box 487, Robbinsville, NJ 08691 609-259-2776 609-259-3047-Fax

NJSIAA STEROID TESTING POLICY

CONSENT TO RANDOM TESTING

In Executive Order 72, issued December 20, 2005, Governor Richard Codey directed the New Jersey Department of Education to work in conjunction with the New Jersey State Interscholastic Athletic Association (NJSIAA) to develop and implement a program of random testing for steroids, of teams and individuals qualifying for championship games.

Beginning in the Fall, 2006 sports season, any student-athlete who possesses, distributes, ingests or otherwise uses any of the banned substances on the attached page, without written prescription by a fully-licensed physician, as recognized by the American Medical Association, to treat a medical condition, violates the NJSIAA's sportsmanship rule, and is subject to NJSIAA penalties, including ineligibility from competition. The NJSIAA will test certain randomly selected individuals and teams that qualify for a state championship tournament or state championship competition for banned substances. The results of all tests shall be considered confidential and shall only be disclosed to the student, his or her parents and his or her school. No student may participate in NJSIAA competition unless the student and the student's parent/guardian consent to random testing.

By signing below, we consent to random testing in accordance with the NJSIAA steroid testing policy. We understand that, if the student or the student's team qualifies for a state championship tournament or state championship competition, the student may be subject to testing for banned substances.

Signature of student-athlete

Date

Signature of parent/guardian

Date



1161 Route 130, P.O. Box 487, Robbinsville, NJ 08691 609-259-2776 609-259-3047-Fax

NJSIAA Banned-Drug Classes 2006 - 2007

The term "related compounds" comprises substances that are included in the class by their pharmacological action and/or chemical structure. No substance belonging to the prohibited class may be used, regardless of whether it is specifically listed as an example.

Many nutritional/dietary supplements contain NJSIAA banned substances. In addition, the U. S. Food and Drug Administration (FDA) does not strictly regulate the supplement industry; therefore purity and safety of nutritional dietary supplements cannot be guaranteed. Impure supplements may lead to a positive NJSIAA drug test. **The use of supplements is at the student-athlete's own risk.** Student-athletes should contact their physician or athletic trainer for further information.

The following is a list of banned-drug classes, with examples of banned substances under each class:

(a) Stimulants

amiphenazole
amphetamine
bemigrade
benzphetamine
bromantan
caffeine¹ (guarana)
chlorphentermine
cocaine
cropropamide
crothetamide
diethylpropion
dimethylamphetamine
doxapram
ephedrine
(ephedra, ma huang)
ethamivan
ethylamphetamine
fencamfamine
meclofenoxate
methamphetamine
methylenedioxymethamphetamine
(MDMA, ecstasy)
methylphenidate
nikethamide
pemoline
pentetrazol
phendimetrazine
phenmetrazine
phentermine
phenylpropanolamine (ppa)
picrotoxine
pipradol
prolintane
strychnine
synephrine
(citrus aurantium, zhi shi, bitter orange)

and related compounds

(b) Anabolic Agents

anabolic steroids

androstenediol
androstenedione
boldenone
clostebol
dehydrochlormethyl-
testosterone
dehydroepiandro-
sterone (DHEA)
dihydrotestosterone (DHT)
dromostanolone
epitrenbolone
fluoxymesterone
gestrinone
mesterolone
methandienone
methenolone

methyltestosterone
nandrolone
norandrostenediol
norandrostenedione
norethandrolone

oxandrolone
oxymesterone

oxymetholone
pregnelone
stanozolol

testosterone²
tetrahydrogestrinone
(THG)

trenbolone

and related compounds

other anabolic agents

clenbuterol

(c) Diuretics

acetazolamide
bendroflumethiazide
benzhiazine
bumetanide
chlorothiazide
chlorthalidone
ethacrynic acid
flumethiazide
furosemide
hydrochlorothiazide
hydroflumethiazide
methyclothiazide
metolazone
polythiazide
quinethazone
spironolactone
triamterene
trichlormethiazide
and related compounds

(d) Peptide Hormones & Analogues:

corticotrophin (ACTH)
human chorionic gonadotrophin (hCG)
leutenizing hormone (LH)
growth hormone (HGH, somatotrophin)
insulin like growth hormone (IGF-1)

All the respective releasing factors of the above-mentioned substances also are banned:

erythropoietin (EPO)
darbypoetin
sermorelin

(e) Definitions of positive depends on the following:

¹ for caffeine – if the concentration in urine exceeds 15 micrograms/ml

² for testosterone – if administration of testosterone or use of any other manipulation has the result of increasing the ratio of the total concentration of testosterone to that of epitestosterone in the urine of greater than 6:1, unless there is evidence that this ratio is due to a physiological or pathological condition.