

## 10.0 Appendix

### Treatment Contract

(\_\_\_\_\_Athlete Name)

The following items are mandatory and must be completed as prescribed. Failure to do so will result in the consequences listed below the requirements. All benefits and consequences are subject to change at any time and at the discretion of the Multidisciplinary Team.

#### Multidisciplinary Team:

\_\_\_\_\_(Physician), \_\_\_\_\_(Mental Health Provider), \_\_\_\_\_(Dietitian).

#### Requirements:

- Meet with \_\_\_\_\_ (mental health provider) 1x per week, or as recommended by mental health provider.
- Meet with \_\_\_\_\_ (dietitian) 1x per week, or as recommended by dietitian.
- Meet with Dr. \_\_\_\_\_ 1-2x per month, or as recommended by Dr. \_\_\_\_\_.
- Follow daily meal plan set forth by sports dietitian.
- Keep daily workout log updated with specific type, length, and effort.
- Weight gain of \_\_\_\_\_ lbs per week.
- Weekly weigh-in with \_\_\_\_\_(name team member), or at time intervals of \_\_\_\_\_ weeks.
- Must achieve minimal acceptable body weight of \_\_\_\_\_ lbs by \_\_\_\_\_ (date).
- After this date, must maintain weight at or above minimal acceptable body weight.
- Limit of \_\_\_\_\_workout sessions per week with no one session being more than \_\_\_\_\_ minutes in length. All activity counts (e.g., biking, running, weight lifting, and swimming).

#### Benefits:

If ALL requirements are met then clearance to participate in team activities and use of athletic facilities will:  be granted continue.

#### Consequences:

If ANY requirement(s) are not met then clearance to participate in team activities and use of athletic facilities will be revoked, and re-instatement will be at the discretion of the team physician and multidisciplinary team.

I, \_\_\_\_\_ have read this contract and all of my questions were answered.

_____ Athlete Name	_____ Athlete Signature	_____ Date
_____ Team Physician Name	_____ Team Physician Signature	_____ Date