RETURN TO COMPETITION, PRACTICE, OR TRAINING

This form is to be used after a youth athlete is removed from, and not returned to, competition, practice, or training after exhibiting concussion symptoms. The youth athlete should not be returned to competition, practice, or training until written authorization is obtained from an appropriate health care professional and the parent/guardians. A licensed health care provider is a person who is:
(1) Registered, certified, licensed, or otherwise recognized in law by the State of South Dakota to provide medical treatment; and
(2) Trained and experienced in the evaluation, management, and care of concussions.

This form should be kept on file at the school and need not be forwarded to the SDHSAA Office.

Athlete:_____ School: _____ Grade: _____

Sport: _____ Date of Injury: _____

REASON FOR ATHLETE'S INCAPACITY

_____

_____

_____

Guidelines for returning to competition, practice, or training after a concussion

Note: Each step should be completed with no concussion symptoms before proceeding to the next step.

1. No activity, complete rest with no symptoms.
2. Light exercises: walking or stationary cycling with no symptoms.
3. Sport specific activity without body contact and no symptoms.
4. Practice without body contact and no symptoms. Resume resistance training.
5. Practice with body contact and no symptoms.
6. Return to game play with no symptoms.

Note:

1. If symptoms return at any time during the rehabilitation process, wait until asymptomatic for 1 full day, then re-start at the previous step.
2. Never return to competition with symptoms.
3. Do not use "smelling salts".
4. **When in doubt, sit them out.**

HEALTH CARE PROFESSIONAL'S ACTION

I have examined the named student-athlete following this episode and determined the following:

_____ **Permission is granted** for the athlete to return to competition, practice, or training

_____ **Permission is not granted** for the athlete to return to competition, practice, or training

COMMENT:_____

_____

_____

_____ Date: _____
Health Care Professional

_____ Date: _____
Parent/Guardian

_____ Date: _____
School Administrator