



# 2025 – 2026 Sioux Falls Public Schools Activity Participation Packet

COMPLETED ANNUALLY PRIOR to any participation in activities, which includes, but is not limited to, the first practice, workout (summer included) or tryout of an activity in which the student is participating in.

The Sioux Falls School District is committed to preparing our students for purposeful engagement in the world through participation in activities. Students in Grades 7 - 12 have the opportunity to participate in the middle and high school interscholastic athletics and/or activities programs, including school sponsored sports. For those students interested in participating in the Sioux Falls School District activities program during the 2025-26 school year, the following information MUST be on file PRIOR to any participation in activities, which includes, but is not limited to, the first practice, workout (summer included) or tryout of an activity in which the student is participating in.

### WARNING AND SAFETY STATEMENT

Although participation in supervised interscholastic activities may be one of the least hazardous any student will engage in, by its nature participation in these activities includes a risk of injury which may range in severity from minor to catastrophic injuries, including permanent paralysis or death. Serious injuries are not common in supervised school activity programs; however, it is possible only to minimize, not eliminate this risk.

### MEDICAL INSURANCE

It is the responsibility of the parent/guardian to provide adequate insurance to cover any medical expenses that may be incurred while a student is participating in a school-sponsored activity. Student accident insurance can be obtained at: <https://www.sas-mn.com/sas/k12.php>

### YEAR-ROUND ACTIVITY RULES

We have read the [Sioux Falls School District Year-round Activity Rules \(Board Policy JJAA-R\)](#) and agree to abide by its rules and regulations.

### SDHSAA RULES AND REGULATIONS

A student who is a member of a **high school team** is subject to all SDHSAA Rules and Regulations. A copy of these rules and regulations may be found at: <https://www.sdhsaa.com/athletic-handbook/>

**By signing below, we acknowledge that we agree to all of the above statements and rules, as well as the Consent for Release of Medical Information (HIPAA), and Consent for Medical Treatment.**

STUDENT: \_\_\_\_\_ GENDER: F  M  SCHOOL: \_\_\_\_\_  
(Please Print)

STUDENT ID#: \_\_\_\_\_ DOB: \_\_\_\_\_ GRADE: \_\_\_\_\_  
FALL 2025

PARENT/LEGAL GUARDIAN: \_\_\_\_\_ RELATIONSHIP: \_\_\_\_\_  
(Please Print)

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_

STATE: \_\_\_\_\_ ZIP: \_\_\_\_\_ HOME PHONE: \_\_\_\_\_

**STUDENT SIGNATURE:** \_\_\_\_\_ Date: \_\_\_\_\_ 20\_\_\_\_

**PARENT/LEGAL GUARDIAN SIGNATURE:** \_\_\_\_\_ Date: \_\_\_\_\_ 20\_\_\_\_

Please complete ALL pages of this packet and sign where indicated.

## Concussion Facts for Athletes

### What is a concussion?

A concussion is a brain injury that:

- Is caused by a bump, blow, or jolt to the head or body
- Can change the way your brain normally works
- Can occur during practices or games in any sport or recreational activity
- Can happen even if you have not been knocked out
- Can be serious even if you have just been “dinged” or “had your bell rung”

All concussions are serious. A concussion can affect your ability to do schoolwork and other activities (such as playing video games, working on a computer, studying, driving, or exercising). Most people with a concussion get better, but it is important to give your brain time to heal.

### What are the symptoms of a concussion?

You cannot see a concussion, but you might notice one or more of the symptoms listed below or that you “don’t feel right” soon after, a few days after, or even weeks after the injury.

- Headache or “pressure” in head
- Nausea or vomiting
- Balance problems or dizziness
- Double or blurry vision
- Bothered by light or noise
- Feeling sluggish, hazy, foggy, or groggy
- Difficulty paying attention
- Memory problems
- Confusion

### What should I do if I think I have a concussion?

- Tell your coaches and your parents. Never ignore a bump or blow to the head even if you feel fine. Also, tell your coach right away if you think you have a concussion or if one of your teammates might have a concussion.
- Get a medical check-up. A doctor or other health care professional can tell if you have a concussion and when it is OK to return to play.
- Give yourself time to get better. If you have a concussion, your brain needs time to heal. While your brain is still healing, you are much more likely to have another concussion. Repeat concussions can increase the time it takes for you to recover and may cause more damage to your brain. It is important to rest and not return to play until you get the OK from your health care professional that you are symptom-free.

### How can I prevent a concussion?

Every sport is different, but there are steps you can take to protect yourself.

- Use the proper sports equipment, including personal protective equipment. For equipment to protect you, it must be:
  - The right equipment for the game, position, or activity
  - Worn correctly and the correct size and fit
  - Used every time you play or practice
- Follow your coach’s rules for safety and the rules of the sport
- Practice good sportsmanship at all times

**It is better to miss one game than the whole season.**

Student Signature

Date

Parent/Guardian Signature

Date

[For More Information From SFSD Medical Providers \(Click Here\)](#)

## Concussion Facts for Parents

### What is a concussion?

A concussion is a brain injury. Concussions are caused by a bump, blow, or jolt to the head or body. Even or what seems to be a mild bump or blow to the head can be serious.

### What are the signs and symptoms?

You cannot see a concussion, Signs and symptoms of concussion can show up right after the injury or may not appear or be noticed until days after the injury. If your teen reports, one or more symptoms of concussion listed below, or if you notice the symptoms yourself, keep your teen out of play and seek medical attention right away.

Signs Observed by Parents/Guardians	Symptoms Reported by Athlete
<ul style="list-style-type: none"> <li>• Appears dazed or stunned</li> <li>• Is confused about assignment or position</li> <li>• Forgets an instruction</li> <li>• Is unsure of game, score, or opponent</li> <li>• Moves clumsily</li> <li>• Answers questions slowly</li> <li>• Loses consciousness (even briefly)</li> <li>• Shows mood, behavior, or personality changes</li> <li>• Cannot recall events prior to hit or fall</li> <li>• Cannot recall events after hit or fall</li> </ul>	<ul style="list-style-type: none"> <li>• Headache or “pressure” in head</li> <li>• Nausea or vomiting</li> <li>• Balance problems or dizziness</li> <li>• Double or blurry vision</li> <li>• Sensitivity to light or noise</li> <li>• Feeling sluggish, hazy, foggy, or groggy</li> <li>• Concentration or memory problems</li> <li>• Confusion</li> <li>• Just not “feeling right” or is “feeling down”</li> </ul>

### How can you help your teen prevent a concussion?

Every sport is different, but there are steps your teens can take to protect themselves from concussion and other injuries.

- Make sure they wear the right protective equipment for their activity. It should fit properly, be well maintained, and be worn consistently and correctly.
- Ensure that they follow their coaches’ rules for safety and the rules of the sport
- Always encourage them to practice good sportsmanship.

### What should you do if you think your teen has a concussion?

1. **Keep your teen out of play.** If your teen has a concussion, her/his brain needs time to heal. Do not let your teen return to play the day of the injury and until a health care professional, experienced in evaluating for concussion, says your teen is symptom-free and it is OK to return to play. A repeat concussion that occurs before the brain recovers from the first - usually within a short period of time (hours, days, or weeks) - can slow recovery or increase the likelihood of having long-term problems. In rare cases, repeat concussions can result in edema (brain swelling), permanent brain damage, and even death.
2. **Seek medical attention right away.** A health care professional experienced in evaluating for concussion will be able to decide how serious the concussion is and when it is safe for your teen to return to sports.
3. **Teach your teen that it is not smart to play with a concussion. Rest is key after a concussion.** Sometimes athletes wrongly believe that it shows strength and courage to play injured. Discourage others from pressuring injured athletes to play. Do not let your teen convince you that s/he is “just fine”.
4. **Tell all your teen’s coaches and the student’s school nurse about ANY concussion.** Coaches, school nurses, and other school staff should know if your teen has ever had a concussion. Your teen may need to limit activities while s/he is recovering from a concussion. Things such as studying, driving, working on a computer, playing video games, or exercising may cause concussion symptoms to reappear or get worse. Talk to your health care professional, as well as your teen’s coaches, school nurse, and teachers. If needed, they can help adjust your teen’s school activities during her/his recovery.

Parent/Guardian Signature

Date

# Medication Self-Administration for Students during Student Travel\*

\*As defined in JJH/JJH-R Student Travel & JLCD/JLCD-R Medication Administration

## **Medication:**

All prescribed medications, all over-the-counter (non-prescribed medications) and all chemical/homeopathic substances and compounds, including but not limited to natural remedies, herbs and vitamins\*, which purport to aid in a person's health or well-being or to treat illness or disease.

Student Name: \_\_\_\_\_

Activity: \_\_\_\_\_

My student will self-administer the following Medication(s) (name/dose/time):

\_\_\_\_\_  
\_\_\_\_\_

My student will not need to take medications during travel

I acknowledge that my student will be self-administering the above medication during his/her school activity outside of the school day. I understand that the school district and individuals involved will not be liable for the medication administration, lack thereof, or adverse effects of the medication.

I understand that I am responsible for notifying the school and updating this form if there are new medications or updates to the medication listed above.

I understand my student will only take with them the amount of medication needed during the trip.

**Parent/Guardian Signature:** \_\_\_\_\_

**If you do not feel your child is able to self-administer their medication, please contact your building Activity Director or School Nurse.**

## **Misuse of All Medication**

Students are prohibited from transferring, delivering or receiving any medication to or from another student. All violations will result in confiscation of the medication and subject student(s) to discipline in accordance with the District's progressive discipline policy. Students who use medication for purposes other than for its intended use will be disciplined and will no longer be allowed to carry and self-administer medications.

### CONSENT FOR MEDICAL TREATMENT

I am the mother / father / legal guardian of (student named below) who participates in activities in the Sioux Falls Public School System. I hereby consent to any medical services and hospital care that may be required while said student is under the supervision of an employee of Sioux Falls Schools while involved in a school-sponsored/ approved activity. I hereby appoint said employee to act on my behalf in securing necessary medical services and hospital care from any duly licensed health care provider. I understand that action on the part of District personnel does not obligate personnel or the school system to assume financial responsibility for the transportation or treatment of the student (Board Policy J1C1E).

#### HEALTH HISTORY

Student's Name: \_\_\_\_\_ ID #: \_\_\_\_\_  
Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_  
Student's Religion (optional): \_\_\_\_\_  
Parent/Legal Guardian: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
Insurance Company: \_\_\_\_\_ Insured Person: \_\_\_\_\_  
Policy Number: \_\_\_\_\_  
Father/Step-Father Work Phone: \_\_\_\_\_  
Mother/Step-Mother Work Phone: \_\_\_\_\_  
If we are unable to reach you in an emergency, whom should we contact?  
Emergency Name: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
Emergency Name: \_\_\_\_\_ Phone: \_\_\_\_\_  
Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_  
Hospital Preference: \_\_\_\_\_

#### MEDICAL INFORMATION

Family Doctor: \_\_\_\_\_ Date of Last Tetanus Shot: \_\_\_\_\_  
Any Allergies: \_\_\_\_\_  
Any Major Medical Problems (i.e. Heart, blood pressure, diabetes): \_\_\_\_\_  
Allergic to any Medications: \_\_\_\_\_

LEGAL REPRESENTATIVE SIGNATURE: \_\_\_\_\_

DATE

Circle one: Parent Legal Guardian Other

#### CONSENT OF STUDENT

I have read the above consent form signed by my mother / father / legal guardian and join with him/her in consent.

STUDENT SIGNATURE: \_\_\_\_\_

DATE

### AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION (HIPAA)

(Health Insurance Portability and Accountability Act)

STUDENT: \_\_\_\_\_ GENDER: F  M

(Please Print)

DOB: \_\_\_\_\_ GRADE: \_\_\_\_\_

FALL 2025

1. I authorize the use or disclosure of the above-named individual's health information which may include the Preparticipation History and Physical Evaluation information pertaining to a student's ability to participate in school-sponsored/ approved activities. Such disclosure may be made by a health care provider generating or maintaining such information for the purposes of evaluating, observing, diagnosing, and creating treatment plans for injuries that occur during the time period covered by this form or pre-existing conditions that require care plans pertaining to participation during the time period covered by this form.
2. The information identified above may be used by or disclosed to the school nurse, athletic trainer, coaches, school approved volunteer, medical providers and other school personnel involved in the medical care of this student.
3. This information for which I am authorizing disclosure will be used for the purpose of determining the student's eligibility to participate in activities, any limitations on such participation and any treatment needs of the student.
4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the school administration. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
5. This authorization will expire on: 6/31/2026
6. I understand that once the above information is disclosed, the recipient may re-disclose it and federal privacy laws or regulations may not protect it and the information. Schools and school districts are educational agencies and institutions under FERPA. Disclosure and re-disclosure by schools or school employees must meet FERPA requirements, including parental consent if no exception applies.
7. I understand authorizing the use or disclosure of the information identified above is voluntary. However, a student's eligibility to participate in activities depends on such authorization. I need not sign this form to ensure healthcare treatment.

LEGAL REPRESENTATIVE SIGNATURE: \_\_\_\_\_

DATE

Circle one: Parent Legal Guardian Other

STUDENT SIGNATURE: \_\_\_\_\_

DATE