**RE-SOCIALIZATION PLAN FOR STUDENT-ATHLETE ACTIVITIES AFTER MENTAL HEALTH EXACERBATION**

Below is a treatment plan outlined by sports medicine staff and consultants who will serve as your treatment team to help assist you with progressing back to student and athletic related activities here at the University of Mississippi. This treatment plan was formulated by the team and serves as minimum expectations to help ensure safe return to pre-hospitalization activities, and will be re-evaluated on a regular basis to ensure goals are being met.  Success of this plan will depend on frequent communication between both you and the designated members of the treatment team as indicated.
Listed below are the highlights of the initial phase of this treatment plan, and presented to you in the presence of treatment team members, so that there is mutual understanding of these goals, and it is requested that you initial each of the highlights indicated your understanding of each and had opportunity to discuss any initial concerns or questions with the treatment team.

* **Initial \_\_\_\_\_\_** I agree to picking up my medication from (athletic trainer) in the (facility) athletic training room when it arrives and as it is prescribed from (prescribing physician) for my treatment. I’m in agreement to taking my medication as it prescribed to help my overall mental health.
* **Initial \_\_\_\_\_\_** I will make my weekly appointments with (LMHP) as scheduled – Mondays at 3PM, typically. If I am unable to meet at our weekly scheduled time, I will contact (LMHP) in a timely manner to reschedule an appointment later in the week. I understand that schedule changes for (sport) that conflict with my appointment may necessitate informing (ATC) that I cannot attend the previously unscheduled (sport) related activity. (ATC) will then communicate that with the (sport) coaching staff.
* **Initial \_\_\_\_\_\_** I will attend 3 AA meetings to assess if this would be a helpful added support in my treatment. Should I not find these meetings potentially helpful, I understand that I will be asked to work with (LMHP) on finding an alternative support.
* **Initial \_\_\_\_\_\_** I will attend all scheduled appointments with the medical director as they are scheduled. I understand that schedule changes for (sport) that conflict with my appointment may necessitate informing (ATC) that I cannot attend the previously unscheduled (sport) related activity. (ATC) will then communicate that with the coaching staff.
* **Initial \_\_\_\_\_\_** I will attend scheduled appointments with (psychiatrist) that are bi-weekly with the understanding that these appointments may change as he sees fit. I understand that schedule changes for (sport) that conflict with my appointment may necessitate informing (ATC) that I cannot attend the previously unscheduled (sport) related activity. (ATC) will then communicate that with the (sport) coaching staff.
* **Initial \_\_\_\_\_\_** I understand I must meet with sports nutrition 1x a week, that will be coordinated through Athletic Training staff. I understand that schedule changes for (sport) that conflict with my appointment may necessitate informing (ATC) that I cannot attend the previously unscheduled (sport) related activity. (ATC) will then communicate that with the (sport) coaching staff.

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* **Initial \_\_\_\_\_\_** I understand I must attend all classes, tutoring sessions, and study hall hours as assigned by (academic counselor), unless it is an absence excused by the athletic training staff.
* **Initial \_\_\_\_\_\_** I understand I may be subject to random drug assessments.

* **Initial \_\_\_\_\_\_** I understand that part of my treatment plan is communicating with (ATC) or (LMHP) should I begin to have thoughts of ending my life.

I understand and agree I must be in compliance with the plan that the treatment team has formed. After 2 weeks the treatment team will evaluate my progress and progress as they see fit to return to activity.

Print name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_

Witness: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_