

**Department of South Dakota**

**Veterans of Foreign Wars**

3601 South Minnesota Ave.

Sioux Falls, South Dakota 57105

Phone 605-332-7441 Fax 605-332-0617

**Player Medical Information and Permission Form**

Date Signed: \_\_\_\_\_

Name of Player: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Parent's Work: \_\_\_\_\_

Parent/Guardian Name: \_\_\_\_\_

Family Physician: \_\_\_\_\_ Phone: \_\_\_\_\_

Family Dentist: \_\_\_\_\_ Phone: \_\_\_\_\_

I/we hereby give permission for Medical personnel to administer necessary medical treatment to the player named above in the event that I/we are not able to be contacted immediately.

Parent/Guardian Signature \_\_\_\_\_

Please list below and on reverse side of this form any conditions concerning the player named above that the medical personnel should be aware of so the proper medical treatment may be assured.

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Coaches it is recommended that you keep this Medical Permission Form in a place where you can use them if needed.