



## Medical Certification Form for TOPSoccer Participation

Player's Name: \_\_\_\_\_

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

Phone: \_\_\_\_\_

Sex: M \_\_\_ F \_\_\_ Date of Birth: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

- Note to the Physician – If this child has Down Syndrome, TOPSoccer requires that, in order to participate in TOPSoccer, he/she has a complete examination for the purpose of establishing the absence of atlantoaxial instability.

\_\_\_\_\_  
Physician Statement/Information:

Physician's Name: \_\_\_\_\_ Office Phone # \_\_\_\_\_

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

Physician's Comments:

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

I have reviewed the above player's health information and examined the player and certify that there is no medical evidence apparent to me that would preclude him/her from participating in TOPSoccer.

Physician's Signature: \_\_\_\_\_ Date: \_\_\_\_\_