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 radiological 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: _____