



TOPSSoccer Atlanto-axial Instability Certification

Important Note: If your child has Down Syndrome, he/she must have a complete radiological examination for the purpose of establishing the absence of atlanto-axial instability.

Player Information:

Player's Name: _____

Date of Birth (MM/DD/YYYY): _____ Height: _____ Weight: _____

Parent/Guardian Information:

Name: _____

Address: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Physician Statement/Information:

Family Physician: _____ Phone: _____

Address: _____ City, State: _____

Physician's Comments: _____

"I have reviewed the above player's health information, 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: _____