



SPECIAL RELEASE FOR ATHLETES WITH ATLANTO-AXIAL INSTABILITY

CERTIFICATION BY PHYSICIAN

We have examined the athlete named in the application, who has Down Syndrome and who has been diagnosed as having Atlanto-axial Instability. We certify based on our examinations of the athlete and our review of the health information contained in this application, that despite the diagnosis of Atlanto-axial Instability, this athlete is not medically precluded from participation in TOPSoccer. We further certify that we have explained to the athlete named in this application, (and to the parent or guardian whose signature appears below, if the athlete is a minor), the medical risks associated with Atlanto-axial Instability and in particular, the risks associated with the athlete's participation in sports or events which, by their nature, may result in hyper-extension, radical flexion or direct pressure on the neck or upper spine. (Signatures of two physicians are required.)

Restrictions (if any): _____

Physician #1 _____ Physician #2 _____

Physician's Name: _____ Physician's Name: _____

Address: _____ Address: _____

Phone: _____ Phone: _____

Signature of Physician: _____ Signature of Physician: _____

Date: _____ Date: _____

CERTIFICATION OF ADULT ATHLETE

(Required for adult with diagnosis of Atlanto-axial Instability)

I am the athlete named in this application. I certify that:

1. I have been informed by the physicians named above that I have Atlanto-axial Instability.
2. The risks associated with that condition, including the risks from participating in TOPSoccer (a USYouth Soccer program for children and adults with disabilities) have been fully explained to me by the physician named above, and I fully understand the possible medical consequences if I participate in TOPSoccer.
3. Although I recognize and understand the risks and possible medical consequences, I certify that I am taking these risks knowingly and voluntarily, of my own free will, because of my desire to participate in TOPSoccer, based on the certifications of the two physicians named above that I am not medically precluded from participating in TOPSoccer.

Name: _____ Phone: _____

Address: _____

Signature of Adult Athlete: _____ Date: _____

Signature of Adult Friend or Family Member _____ Date: _____

CERTIFICATION OF PARENT

(Required for minor athletes with diagnosis of Atlanto-axial Instability)

I am the mother/father of the athlete named in this application. I certify that:

1. I have been informed by the physicians named above that I have Atlanto-axial Instability.
2. The risks associated with that condition, including the risks from participating in TOPSoccer (a USYouth Soccer program for children and adults with disabilities) have been fully explained to me by the physician named above, and I fully understand the possible medical consequences of my son/daughter participating in TOPSoccer.
3. Although I recognize and understand the risks and possible medical consequences, I hereby give my permission for my son/daughter to participate in TOPSoccer, based on the certifications of the two physicians named above that my son/daughter is not medically precluded from participating in TOPSoccer.

Name: _____ Phone: _____

Address: _____

Signature of Parent/Guardian: _____ Date: _____