PREPHYSICAL FORM

DOWN SYNDROME AND/ OR ATLANTO-AXIAL INSTABILITY (AAI)

PHYSICIAN CERTIFICATIONS AND ASSUMPTION OF RISK FORM
FOR PLAYERS WITH DOWN SYNDROME AND/ OR ATLANTO-AXIAL INSTABILITY (AAI)
A NEW RELEASE IS REQUIRED _____[state how often]

PHYSICIAN CERTIFICATIONS

I. Certification of one (1) Physician required for players with no positive AAI results. I have examined_____("player")_ who has Down Syndrome. He/she has **negative** results for Atlanto-Axial Instability (AAI). I certify that this player has my permission to play.
Physician's Name_____ Phone ( )_____
Address: _____ City: _____State:_____ Zip_____
I have spoken to the parents/legal guardian/player and recommend that the player be examined _____ [state how often] for AAI.
Physician's Signature_____

II. Signature of two (2) Physicians is required for all players with positive AAI results.
I have examined _____("player")who has Atlanto-Axial Instability (AAI). I certify, based on my examination and review of his/her health information, that despite the diagnosis of AAI, this player is not medically precluded from participation in [Name of State Association] TOPSoccer. I further certify that I have explained to the player named in this form, and to the parent or legal guardian whose signature appears below, the medical risks associated with AAI and in particular, the risks associated with the player's participation in soccer and related events which, by their nature, may result in hyper-extension, radical flexion, or direct pressure on the neck or upper spine.
Physician's Name _____ Phone ( )_____
Address :_____ City:_____ State:_____ Zip_____
I have spoken to the parents/legal guardian/player and recommend that the player be examined _____ [state how often] for AAI.
Signature of Physician: _____
Physician's name: _____ Phone ( ) _____
Address _____ City: _____ State:_____ Zip: _____
I have spoken to the parents/legal guardian/player and recommend that the player be examined _____ [state how often] for AAI.
Signature of Physician: _____

III. ASSUMPTION OF RISK
(Required for players with diagnosis of Atlanto-Axial Instability)
I am the parent/legal guardian/player of _____, (hereinafter "the player").
I certify that:
1. I have been informed by the physicians named above that the Player has Atlanto-Axial Instability.
2. The risks associated with that condition, including risks from participating in soccer and related events have been fully explained to me by the physicians named above and I fully understand the risks and possible medical consequences of the player participating in soccer and related events. I understand that soccer is a challenging and physical sport involving contact and potential risk of injury. On behalf of the player, I hereby assume all risks and agree to hold [Name of State Association] harmless from all damages arising therefrom.
3. Although I recognize and understand the risks and possible medial consequences, I hereby give my permission for the player to participate in soccer and related events.

DO NOT SIGN UNTIL YOU HAVE READ THE ENTIRE ASSUMPTION OF RISK SECTION ABOVE
Print Name: _____
Address: _____State _____Zip _____
Signature of Parent/Legal Guardian/ Player: _____
Date: _____