PRSC TOPSOCCER PHYSICIAN MEDICAL FORM

Note to Physician: The following child wishes to play TOPSoccer, an adaptive soccer program for children with special needs (mental and/or physical). A physician's approval is required before the child will be allowed to participate. Please determine if this child has any medical restrictions that would prohibit him/her from playing soccer (e.g. children with Downs Syndrome must have a radiological examination to rule out Atlanto-Axial Instability).

Child's Name: _____ **Date of Birth:** _____

By signing the below, I confirm that I have:

- Reviewed the above named player's medical information;
- Performed a medical examination and/or screening tests, if indicated;
- If the child has a positive diagnosis for Atlanto-Axial Instability, the risks associated with participating in soccer (hyper-extension, radical flexion or direct pressure on the neck) have been discussed with the child's parents; and
- Determined that there is no medical evidence that precludes this child from participating in PRS TOPSoccer.

Physician's Signature: _____ **Date**: _____

Physician's Printed Name: _____

Address: _____ **Phone:** _____

City, State, Zip: _____

THIS FORM WILL BE IN EFFECT ONE YEAR FROM THE DATE SIGNED.

THIS FORM MUST BE RETURNED BY THE PARENT/GUARDIAN: Either bring this form to Chris Caudill at the first TOPSoccer session or SCAN AND EMAIL to ccaudill@prsoccer.com