METRO TULSA Soccer Club, USY
Medical Addendum for Downs Syndrome Athletes
2014

This form must be completed and signed by the examining physician for the individual with Down Syndrome wishing to participate in the Special Needs Soccer Program through the METRO TULSA Soccer Club (MTsc).

Name of Athlete: _____

Gender (M or F): _____ Age: _____ Birthday (mo./day/yr): _____

Home Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell Phone: _____

NOTE TO EXAMINING PHYSICIAN: STUDIES HAVE SHOWN THAT APPROXIMATELY 10% OF PERSONS WITH DOWN SYNDROM HAVE THE CONDITION OF ATLANTOAXIAL DISLOCATION. MTSC TOPSOCCER PROGRAM REQUIRES CERVICAL SPINE X-RAY INCLUDING FULL FLEXION AND FULL EXTENSION VIEWS IN ORDER TO DETERMINE THE EXISTENCE OF DISLOCATION.

PHYSICIAN STATEMENT: On examination of the cervical spine X-rays including full flexion and full extension views, I find the above named athlete has (check one):

☐ No evidence of Atlantoaxial Dislocation.
(Proceed to the next section unless as a result of another condition the athlete should not participate in this activity)

☐ Positive of equivocal evidence of Atlantoaxial Dislocation.
(Proceed to next section and circle all activities in which the individual may participate in on a year-round basis)

I have notified the parents/guardians of the nature and extent of the condition. Please check the one that applies:

YES* ☐ NO ☐ NOT APPLICABLE ☐

*If positive for the dislocation, please complete the following section.

IT IS MY RECOMMENDATION THAT THIS ATHLETE BE ALLOWED TO PARTICIPATE IN THE FOLLOWING ACTIVITIES (Please circle all that apply):

INDIVIDUAL SOCCER SKILLS **TEAM COMPETITION** **NO RESTRICTIONS**

_____ _____
Name of Physician (please print) Address/City/State/Zip Code

_____ _____
Signature of Physician Phone Number