PHYSICIAN CERTIFICATIONS AND ASSUMPTION OF RISK FORM

ATLANTO-AXIAL INSTABILITY (AAI)

Player's Legal First Name: _____ Middle: _____ Last: _____

Date of Birth: _____/_____/_____
Month Day Year

I am the parent/legal guardian of _____ and hereby authorize my physicians to release the information required on this form.

Signature of Parent/Legal Guardian: _____ Phone: ( ) _____
Address: _____City: _____ State: ____ Zip_____
Date: _____

PHYSICIAN CERTIFICATION
NEGATIVE RESULTS

I have examined_____ ("player") who has Down Syndrome and has **negative** results for Atlanto-Axial Instability (AAI). I certify that this player has my permission to play.

Physician #1
Name: _____ Phone: ( ) _____
Address :_____ City:_____ State:____ Zip_____
Date of Examination: _____
Signature of Physician: _____

PHYSICIAN CERTIFICATION
POSITIVE RESULTS

I have examined _____ ("player") who has Down Syndrome and has **positive** results for 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 Washington Youth Soccer 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. (Signature of **two** physicians is required.)

Physician #1
Name: _____
Phone: ( ) _____
Address: _____
City: _____State: ____Zip:_____
Date of Examination: _____
Signature of Physician:
_____

Physician #2
Name: _____
Phone: ( ) _____
Address_____
City: _____ State: ____ Zip: _____
Date of Examination: _____
Signature of Physician:
_____

ASSUMPTION OF RISK

I am the parent/legal guardian of _____ (hereinafter "the player"). I certify that:

1. I have been informed by the physicians named above of the player's Atlanto-Axial Instability status.
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 Washington State Youth Soccer 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.

Parent/Legal Guardian
Name: _____Phone: ( ) _____
Address: _____City: _____ State: ____ Zip_____
Signature of Parent/Legal Guardian: _____
Date: _____

A NEW RELEASE IS REQUIRED EVERY 3 YEARS FROM MOST RECENT MEDICAL EXAM