

PLAYERS NAME _____

DATE OF BIRTH _____ HEIGHT _____ WEIGHT _____

- Note of Physician: If the child has Down Syndrome, TOPSoccer requires that he/she has a full radiological examination establishing the absence of Atlanto-axial Instability before they may play the sport of soccer.

Physical not required, only Doctor's signature. I have reviewed the above players health information and examined the player, and certify there is no medical evidence to me which would preclude him/her from participation in the TOPSoccer Program.

PHYSICIAN'S NAME _____

ADDRESS _____ CITY & STATE _____ ZIP _____

PHYSICIAN'S SIGNATURE _____ DATE _____

PHYSICIAN'S COMMENTS: _____

EMERGENCY PHONE (____) _____ - _____ EMERGENCY CONTACT NAME _____

INSURANCE COMPANY _____ POLICY# _____

HEALTH INFORMATION (CIRCLE THOSE APPROPRIATE)

- | | | |
|------------------|---------------------------|-----------------------|
| Down Syndrome | Atlanto-axial Instability | Diabetes |
| Heart Problems | Seizure Disorder | Visually Impaired |
| Hearing Impaired | Fainting Spells | Non-Verbal, signs |
| Hepatitis | Bleeding Problems | Mobility Impairment |
| Asthma | Emotional Problems | Learning Disabilities |
| Allergies | High Blood Pressure | Low Blood Pressure |

OTHERS: please list any information that the coaching staff needs to know about your child, use the back of this form if you need more room

LIST AIDS USED (such as a wheelchair, hearing aid, glasses etc. please list any information that the coaching staff needs to know about your child, use the back of this form if you need more room)

LIST ALLERGIES

MEDICATIONS:

NAME	DOSEAGE	TIME GIVEN	SIDE EFFECTS
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____