

Virginia Youth Soccer Association
Chantilly Youth Association
TOPSoccer Club-Medical Certification Form

This form is to be completed by your child's physician

Player's Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Sex: M__F__ Date of Birth _____ Height: _____ Weight: _____

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Note to the Physician: If this child has Down Syndrome, TOPSoccer requires that, in order to participate in TOPSoccer, he/she has a complete radiological examination for the purpose of establishing the absence of atlantoaxial instability.

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Physician Statement/Information:

Physician's Name: _____

Office Phone #: _____ Fax #: _____

Address: _____

City: _____ State: _____ Zip: _____

Physician's Comments: _____

Restrictions: _____

"I have reviewed the above player's health information and examined the player and certify that there is no medical evidence apparent to me that would preclude him/her from participating in TOPSoccer"

Physician's Signature: _____ Date: _____