TOPSoccer

Virginia Youth Soccer Association
Vienna Youth Soccer
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:**__________

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.

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: ________