

**Arsenal TOPSoccer
MEDICAL CERTIFICATION**

Player's Name _____

Address _____ **City/State** _____ **Zip** _____

Phone _____

Date of Birth _____ **Height** _____ **Weight** _____

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

I have reviewed the above player's 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 _____

Physician's comments: _____

