PHYSICIAN CERTIFICATIONS AND ASSUMPTION OF RISK FORM
FOR PLAYERS WITH DOWN SYNDROME AND/ OR ATLANTO-AXIAL INSTABILITY (AAI)

A NEW RELEASE IS REQUIRED EVERY YEAR

PHYSICIAN CERTIFICATIONS

I. Certification of one (1) Physician required for players with no positive AAI results.

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

Physician's Name____________________________________ Phone ( )____________________

Address: ______________________________ City: ________________ State:_______ Zip________

I have spoken to the parents/legal guardian/player and recommend that the player be examined ____________ [state how often] for AAI.

Physician's Signature______________________

II. Signature of two (2) Physicians is required for all players with positive AAI results.

I have examined ________________________________("player") who has 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 BYSA TOPSoccer. I further certify that I have explained 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.

I have spoken to the parents/legal guardian/player and recommend that the player be examined ____________ [state how often] for AAI.

1. **Physician's name:** ______________________ Phone ( ) ____________________

Address ____________________________ City: ____________________ State:_____ Zip: ________

I have spoken to the parents/legal guardian/player and recommend that the player be examined ____________ [state how often] for AAI.

Signature of Physician: ________________________________

2. **Physician's name:** ______________________ Phone ( ) ____________________

Address ____________________________ City: ____________________ State:_____ Zip: ________

I have spoken to the parents/legal guardian/player and recommend that the player be examined ____________ [state how often] for AAI.

Signature of Physician: ________________________________

III. ASSUMPTION OF RISK

(Required for players with diagnosis of Atlanto-Axial Instability)

I am the parent/legal guardian/player of ______________________________, (hereinafter "the player").

I certify that:

I have been informed by the physicians named above that the Player has Atlanto-Axial Instability. 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 BYSA harmless from all damages arising therefrom. 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.

DO NOT SIGN UNTIL YOU HAVE READ THE ENTIRE ASSUMPTION OF RISK SECTION ABOVE

Print Name: ____

Address: ____State __________Zip ________________

Signature of Parent/Legal Guardian/Player: __________________________ Date:________________