Medical Release Form

Required annually for all players with Down syndrome

Player Name:_____ Date of Birth:_____

Parent / Guardian Names:_____

Address:_____ City:_____

Zip Code:_____ Phone:_____

E-mail Address:_____

Hendricks Community Soccer requires that any player with Down syndrome be examined by a physician for atlantoaxial instability and cleared by that physician prior to participation in the STAR Soccer program.

To be completed by physician

I have examined the above named player who has Down syndrome and have found that this player has:

- ☐ No evidence of atlantoaxial instability.
- ☐ Positive evidence of atlantoaxial instability, and I have advised the parents/guardians of the risks associated with this condition.

Based on the results of my examination,

- ☐ I certify that there is no medical evidence available to me that would preclude this player from participating in the STAR Soccer program.
- ☐ I do not recommend that this child play soccer.

Physician's Name (please print) _____ Phone (____)_____

Address _____ City _____ State _____ Zip _____

Signature of Physician _____

Parents/Gaurdians: Please deliver this completed form to the Director of HCS STAR Soccer prior to your child's participation in the program.