

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: \_\_\_\_\_

.....  
**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: \_\_\_\_\_