



# PLAYER ASSUMPTION OF RISK AND PHYSICIANS' CERTIFICATION FOR PLAYERS WITH DOWN SYNDROME AND ATLANTO-AXIAL INSTABILITY (AAI)

A NEW RELEASE IS REQUIRED EVERY THREE YEARS

## PHYSICIANS' CERTIFICATION

I have examined \_\_\_\_\_ who has Down Syndrome. He/she has **negative** results for Atlanto-Axial Instability (AAI). The player has my permission to play.

**Physician's Name** \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

I have spoken to the parents/guardian/player and recommend he/she player be examined \_\_\_\_\_ (how often) for AAI.

Physician's Signature \_\_\_\_\_

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

I have examined \_\_\_\_\_ who has Down Syndrome and 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 Washington Youth Soccer TOPSoccer. I further certify that I have explained to the player named in this application, and to the parents or legal guardian whose signature appears below, (if the player is a minor), 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.

**Physician's Name** \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address : \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip \_\_\_\_\_

I have spoken to the parents/guardian/player and recommend he/she be examined \_\_\_\_\_ (how often) for AAI.

**Signature of Physician:** \_\_\_\_\_

**Physician's name:** \_\_\_\_\_ Phone ( ) \_\_\_\_\_

Address \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

I have spoken to the parents/guardian/player and recommend he/she be examined \_\_\_\_\_ (how often) for AAI.

**Signature of Physician:** \_\_\_\_\_

## PLAYER'S ASSUMPTION OF RISK

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

I am the mother/father/legal guardian of \_\_\_\_\_, hereinafter "the player". I certify that:

1. I have been informed by the physicians named above that the Player has Atlanto-Axial Instability.
2. 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 Washington Youth Soccer harmless from all damages arising there from.
3. 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/Guardian: \_\_\_\_\_ Date: \_\_\_\_\_