

BSC TOPSoccer Physician's Release

Form (#2)

PLAYERS 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 has 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 _____ DATE _____

PHYSICIAN'S COMMENTS: _____

Return to:

MAIL:

Denise Gehringer
406 Black Forest Dr. Papillion, NE 68133
402-593-6653

FAX:

ATTENTION DENISE GEHRINGER
402-734-4270

<http://www.bscneb.org/page/show/85093-topsoccer>