Huntsville Futbol Club TOPSoccer Program

Medical Information

Season:_____

Player Name:_____

Health Information

	Circle One		Comments
Down Syndrome	Yes	No	_____
Atlantoaxial instability evaluation by x-ray (Circle Yes for Positive, R for Negative)	Yes	R	_____

History of:	Circle One		Comments
Atlantoaxial instability	Yes	No	_____
Diabetes	Yes	No	_____
Heart problems/blood pressure elevation	Yes	No	_____
Seizures	Yes	No	_____
Vision problems and/or less than 20/20 vision in one or both eyes	Yes	No	_____
Hearing aid/hearing problem	Yes	No	_____
Motor impairment requiring special equipment	Yes	No	_____
Type(s) of special equipment/aid used			_____
Bleeding problem	Yes	No	_____
Head injury/history of concussion	Yes	No	_____
Fainting/dizzy spells	Yes	No	_____
Heat illness or cold injury	Yes	No	_____
Hernia or absence of one testicle	Yes	No	_____
Recent contagious disease(s) or hepatitis	Yes	No	_____
Explain if Yes			_____
Kidney problem or loss of function in one	Yes	No	_____
Urinary problem/incontinence	Yes	No	_____
Pregnancy	Yes	No	_____
Bone or joint problems	Yes	No	_____
Contact lens/glasses	Yes	No	_____

Dentures/false teeth	Yes	No	_____
Emotional problems	Yes	No	_____
Special dietary needs	Yes	No	_____
Other	Yes	No	_____

1. Medical condition(s) about which the coaching staff should be aware:

_____

_____

2. Behavioral information that may be of help to the coaching staff:

_____

_____

Special Medication(s)

Medication Name	Amount	Time(s) Usually Taken	Date Prescribed

_____

_____

_____

Known allergies/adverse reactions to medication(s)/food(s): _____

_____

Doctor(s)

Name: _____ Phone: _____

Name: _____ Phone: _____

Name: _____ Phone: _____

Signature

Signature of person completing this Participant Information form
(Parent, guardian, adult athlete)

_____ Date: _____

Huntsville Futbol Club TOPSoccer Program

Medical Certification Form for TOPSoccer Participation

Player's Name: _____

Address: _____

Phone: _____

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 l examination for the purpose of establishing the absence of atlantoaxial instability.

_____

Physician Statement/Information:

Physician's Name: _____Office Phone # _____

Address: _____

Physician's Comments: _____
_____
_____
_____
_____
_____
_____

"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: _____