

Sporting Omaha FC
14706 Giles Rd Omaha, NE
68138



TOPSoccer Medical Certification

Player's Name_____

Address_____ **City/State**_____ **Zip**_____

Phone_____

Date of Birth_____ **Height**_____ **Weight**_____

***Note to Physician: If the child has Down Syndrome, TOPSoccer requires that he/she have 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_____

Physician's comments:_____

Forms may be faxed to: 402-896-1430
Attn: Christina Lewis, SOFC TOPSoccer Coordinator