

Adapted Sports League

School District of Janesville

Student Name _____ Date of Birth _____ Gender M/F
Address _____ Home Phone _____
School _____ Grade _____

I certify that the above student has been medically evaluated for participation in the Adapted Sports League with recommendations documented below. (Student with Down syndrome, evaluation results for Atlantoaxial instability : _____)

Indoor Soccer-Fall

- ☐ Cleared to Participate, no restrictions
- ☐ Not Cleared
- ☐ Cleared with the following restrictions: _____

Floor Hockey-Winter

- ☐ Cleared to Participate, no restrictions
- ☐ Not Cleared
- ☐ Cleared with the following restrictions: _____

Wiffle Ball-Spring

- ☐ Cleared to Participate, no restrictions
- ☐ Not Cleared
- ☐ Cleared with the following restrictions: _____

Physicians Name (Printed/Typed) _____ Date _____

Address _____ Phone _____

Physician Signature _____