



ATLANTOAXIAL INSTABILITY SCREENING FORM

Child's Name: _____ Child's Date of Birth: _____

Kinetic Kids provides sports and fine arts program for children with special needs. The child named above is interested in participating in one or more programs with Kinetic Kids.

- **If this child has received cervical spine x-rays** including neutral, flexion, and extension, I find this child has:
_____ NO evidence of Atlantoaxial Instability per x-ray
OR
_____ POSITIVE or equivocal evidence of Atlantoaxial Instability per x-ray (see below*)

*If Atlantoaxial Instability is present, **please state recommendations, including precautions and exclusions**, concerning participation in sports and recreation activities. Note that activities may include, but are not limited to: gymnastics (i.e. trampoline and forward roll), headfirst diving, and contact sports.

- **If this child has NOT received cervical spine x-rays**, my physical examination, neurological assessment, and professional judgment finds this child:
_____ IS appropriate for Kinetic Kids sports and activities
OR
_____ IS NOT appropriate for Kinetic Kids sports and activities

Physician's printed name

Physician's phone number

Physician's signature

Date completed

**PLEASE RETURN THIS COMPLETED FORM BY EMAIL TO REGISTER@KINETICKIDSTX.ORG
OR BY FAX TO (210) 558-2021**

****Parents** Please be sure to keep a copy of this completed form with your records**