2024

DOWN SYNDROME NEUROLOGICAL DISCLOSURE

Participant Name: _____ **Date of Birth:** _____

TO BE COMPLETED BY PARTICIPANT'S MEDICAL PERSONNEL:

BraveHearts requires the following of all participants with Down syndrome:

- May not participate before the age of 4 years old.
- May not participate if they demonstrate any symptoms of atlantoaxial instability, positive clinical signs as noted by the physician, or a significant measurement as determined by the physician.
- **All participants 5 years old and older, who have a diagnosis of Down syndrome, must have an ANNUAL evaluation and report completed by a physician (new X-rays are not required).**
- **If participant is under 5 years old, they MUST have initial lateral view x-rays taken of the upper cervical region in full flexion and extension. X-rays taken prior to the age of three years old are not reliable, therefore unacceptable, as areas involved may not have ossified. These x-rays must be completed and reported to BraveHearts annually along with completed evaluation and report for participants to be considered for services.**

Date X-Rays Taken: _____

Name of Physician reviewing X-rays: _____

Phone of Physician: _____

Address of Physician: _____

Significant findings: _____

AN ANNUAL MEDICAL EXAMINATION WITH SPECIAL REFERENCE TO NEUROLOGICAL FUNCTION:

Name of Medical Personnel examining Participant: _____

Phone of Medical Personnel: _____

Address of Medical Personnel: _____

Significant findings: _____

Annual certification from a physician for the participant's annual physical examination must exhibit no symptoms of atlantoaxial instability (AAI).

Certification from the Participant's Medical Personnel

I hereby certify this examination of _____ (participant's name) completed on _____ (date of exam) did not reveal any symptoms of atlantoaxial instability (AAI) or focal neurological disorder.

Medical Personnel's Name: _____ Hospital/Clinic: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

I, the undersigned, do hereby verify the truth and completeness of all the above disclosures.

Medical Personnel's Signature: _____ **Date:** _____

BraveHearts

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