MEDICAL DIAGNOSIS FORM FOR ATHLETES WITH PHYSICAL DISABILITIES:

In order to be classified as an eligible athlete, it is necessary to complete this form together with the athlete's relevant medical information.
Should further information be required for a proper classification, the Federation reserves the right to request it. reserves the right to request it.

The form must be completed by a registered medical practitioner.

The Athlete will not be able to obtain a classification until all requested information has been provided.

Full name	
Gender: ○ Female ○ Male	Date of birth:
Federation	Federative licence number
Medical information (to be completed by a registered medical practitioner)	
Medical diagnosis (Health status)	
Description of affected body parts and limitation	

Primary Impairment resulting from Medical Diagnosis

	Muscle power deficiency
	Passive range of motion impairment
	Ataxia
	Atetosis
	Hypertonia
	Leg length deficiency
	Limb impairment
	Short stature (…….cm)

The Medical Condition is:

	Permanent
	Stable
	Progressive
	Fluctuating

Starting year:

	From birth (congenital) Date of
	Date of onset

Diagnostic evidence to be attached

- Medical diagnostic report and results of complementary physical examinations (e.g. ASIA scale for spinal cord injury, Modified Ashwoth scale for cerebral palsy, X-ray for dysmelia, photo in case of amputation).

The Federation_____belonging to WAKO (World Association of Kickboxing Organisations) reserves the right to request additional diagnostic information including but not limited to:

- Diagnostic reports, e.g. EMG, MRI, CT scan, X-rays

Treatment history
Usual medication (indicate dosage and reason)
Presence of additional diagnoses or medical conditions: ○ Intellectual disability ○ Visual impairment ○ Hearing impairment ○ Mental disorder ○ Impaired respiratory function ○ Alteration of metabolic functions ○ Alterations in cardiac functions ○ impaired muscular endurance (e.g. chronic fatigue) ○ Hypermobility/joint instability ○ Others:
I confirm that the above information is true.

Doctor's name	Doctor's registration number
Medical speciality	Address
City	Province
Telephone	Email
Date	Signature