INSTRUCTION

Medical **D**iagnostic **F**orm
For athletes with Assistive Devices

WORLD PARA TAEKWONDO

WHEELCHAIR P50

EN

- This form must be completed in ENGLISH by the Member National Association (MNA)'s physician or team doctor.

- Must be submitted by REGISTRATION DEADLINE of the event through *https://db.ipc-services.org/wtcs/app/login*

- Must have MEDICAL REPORT in ENGLISH submitted to WTCS.

- PHOTO of the athlete is MANDATORY.
- See PHOTO GUIDE next page.
- Must be submitted also to WTCS under supporting documents.

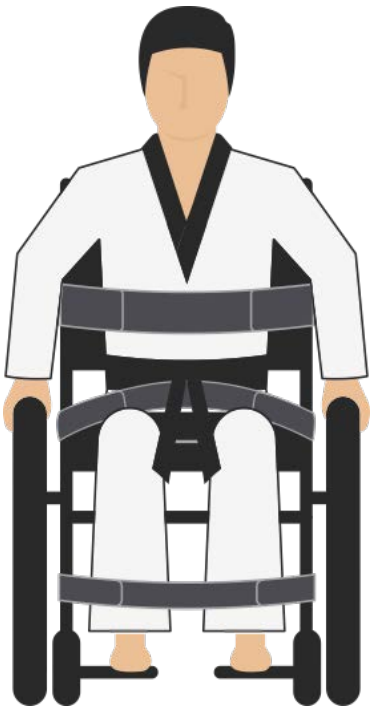
- The Assessment group may ask for further documents to be submitted depending on the individual athlete's health condition and impairment.

- For further information, please contact Para Taekwondo Department at *classification@worldtaekwondo.org*

PHOTO GUIDE

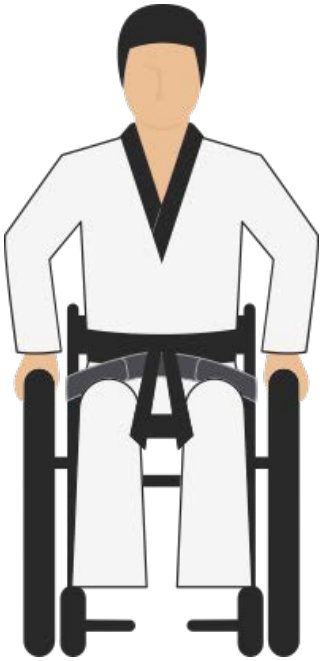
Medical **D**iagnostic **F**orm
For athletes with Assistive Devices

WORLD PARA TAEKWONDO

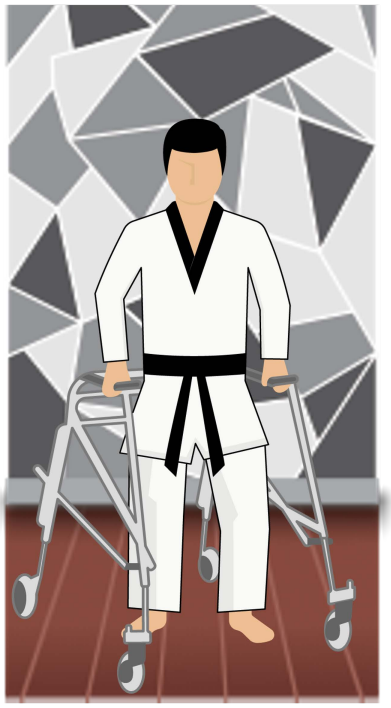


Frontal view, clear background
Wheelchair straps showing ✓

Impaired limbs showing ✓



Impaired limb not showing ✗



Background ✗

MDF

Medical **D**iagnostic **F**orm
For athletes with Assistive Devices

WORLD PARA TAEKWONDO

Athlete Information

First Name:		Last Name:	
Date of Birth *dd/mmm/yyyy:*		Gender:	-
Discipline:	-	How long competing:	
Member National Association:		WT License:	

Eligible Impairment (s):

☐ Hypertonia/ Spasticity ☐ Athetosis ☐ Dystonia ☐

☐ Limb deficiency ☐ Impaired Muscle Power ☐ Impaired Passive Range of Movement

Underlying Health Condition:

☐ Brain or spinal cord injury ☐ Brain stroke ☐ Peripheral nerve injury ☐ Cerebral Palsy

☐ Amputation ☐ Dysmelia/malformation ☐ Joint contracture ☐ Polyomylitis

Others, specify:

Details of the impairment *(Please give details of the medical condition, severity and how many limbs affected):*

Health condition is:	-	-
If acquired, age of onset:		
Other health conditions:	-	
Medication (s):	-	

Declaration signed by MNA physician or Team doctor:

☐ **I confirm that the above information is accurate.**

Name:			
Health care profession:			
Professional registration number:			
Address:			
City:		Country:	
Phone:		E-mail:	
Date *dd/mmm/yyyy*:		Signature:	

CHECKLIST
Tick all applicable options

☐ Medical report *(must contain -clear diagnosis -severity -which limbs are affected -how stable is the condition.*

☐ Others, please specify:

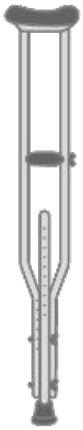
ASSISTIVE DEVICES

Medical **D**iagnostic **F**orm
For athletes with Assistive Devices

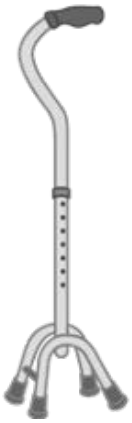
WORLD PARA TAEKWONDO

Please tick which Assistive Device your athlete uses:

Forearm crutch ☐

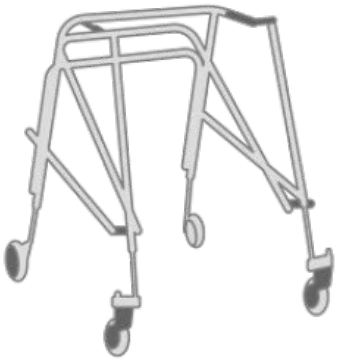


Auxiliary crutch ☐

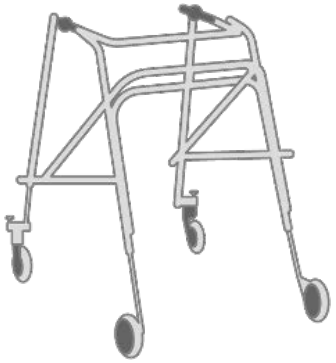


Four leg pyramid cane ☐

Crab foot cane ☐

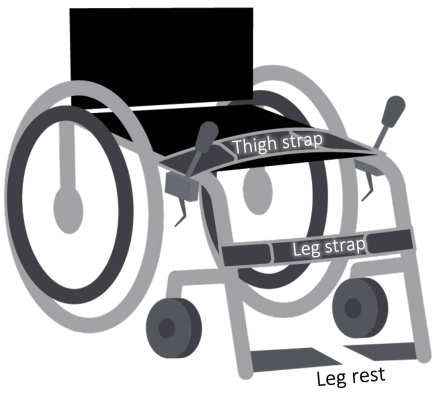


Reverse Walker ☐



Anterior Walker ☐

Long back wheelchair ☐



Short back wheelchair ☐