Medical Diagnostics Form
for World ParaVolley Athletes

The form must be completed in English by a registered medical doctor (M.D.) with a specialization of the Athlete's Health Condition.

The completed form with attached medical documentation must be forwarded to World ParaVolley at classification@worldparavolley.org. This applies for all athletes with an impairment competing in World ParaVolley Events. Depending on the athlete's health condition and impairment, additional medical information is to be attached to this form (see page 2).

Note
The measurement of impairment seen during athlete evaluation must correspond to the diagnosis indicated below. If the medical documentation is incomplete, World ParaVolley holds the right to request further information. In the absence of such information, the athlete will not be able to proceed with Athlete Evaluation.

Athlete Information
(to be prepopulated by the NPC)

Family name:			
Given name:			
Gender:	◯ Female ◯ Male	Date of Birth:	(dd/mm/yyyy)
NPC:		SDMS ID:	
◯ The athlete's Sport Class Status is New		◯ The athlete's Sport Class Status is Review	

Medical Information

Note: The list of medical diagnosis shows examples and is not exhaustive.

Eligible Impairment	**Name medical diagnosis relevant to impairment type (tick or add)**	**Documents to support the diagnosis (tick/add**
☐ Impaired muscle power	☐ Spinal Cord Injury ☐ Muscular Dystrophy ☐ Spina Bifida ☐ Polio Myelitis ☐ Multiple sclerosis ☐ Other_____ _____	☐ Medical Report ☐ ASIA scale ☐ Electromyography ☐ MRI ☐ X-rays ☐ Biopsy ☐ Other_____
☐ Impaired passive range of motion	☐ Arthrogryposis ☐ Joint Contractures ☐ Trauma ☐ Other_____ _____	☐ Medical Report ☐ X-rays ☐ Photographs ☐ Goniometric ROM
☐ Ataxia ☐ Athetosis ☐ Hypertonia	☐ Cerebral Palsy ☐ Traumatic brain injury ☐ Multiple Sclerosis ☐ Stroke ☐ Other_____	☐ Medical Report ☐ Modified Ashworth Scale ☐ Cerebral MRI or TC scan ☐ Other_____
☐ Leg length difference	☐ Trauma ☐ Dysmelia ☐ Other_____ _____	☐ Medical Report ☐ X-rays ☐ Photograph ☐ Other_____
☐ Limb deficiency	☐ Dysmelia ☐ Traumatic Amputation ☐ Bone Cancer ☐ Other_____	☐ Medical Report ☐ X-rays ☐ Photographs ☐ Other_____

Medical history:

Athlete's Condition is:	☐ Stable	☐ Progressive	☐ Fluctuating	☐ Permanent	☐ Congenital
Year of onset:	(yyyy)				
Past treatments:					
Current treatments:					
Anticipated future Treatments:					

Additional details on medical diagnosis (if needed):

Medications and reason for prescription:

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

Name:	
Medical Specialty:	
Registration Number:	
Address:	
City:	Country:
Phone:	E-mail:
Date:	Signature: