

## Underlying Health Condition Assessment Medical Diagnostic Information Form

In order to participate in any IGF Covered Competitions, players are required to provide detailed medical information confirming they have a permanent and verified disability that results in an impairment eligible under the IGF Classification Rules.

This document must be completed in English by a qualified medical doctor (preferably with expertise related to the athlete's initial presentation at an IGF Covered Competition where classification assessment is available).

During classification, the observed impairment must align with the diagnosis stated in the submitted documents. If the medical paperwork is insufficient, IGF reserves the right to request additional information. Without the required documentation, the player cannot proceed to the evaluation stage.

### Player Information:

**Last Name:** \_\_\_\_\_

**First Name:** \_\_\_\_\_

**Date of birth (dd/mm/yyyy):** \_\_\_\_\_

**Place of Birth:** \_\_\_\_\_

**Nationality:** \_\_\_\_\_

**Gender:**  Female       Male

New player being classified for the first time       Player has an existing Sport Class

### Medical Information:

Note: The medical diagnoses shown are as per the IGF Classification Rules.

Underlying Health Condition	Name of Medical diagnosis relevant to the impairment type (tick or add)	Documents/evidence to support the diagnosis (tick and add to all that apply)
<input type="checkbox"/> Impaired Muscle Power	<input type="checkbox"/> Spinal Cord Injury <input type="checkbox"/> Muscular Dystrophy <input type="checkbox"/> Spina Bifida <input type="checkbox"/> Polio Myelitis <input type="checkbox"/> Multiple Sclerosis  Other _____	<input type="checkbox"/> Medical Report <input type="checkbox"/> ASIA Scale <input type="checkbox"/> Electromyography <input type="checkbox"/> MRI (and Medical Report) <input type="checkbox"/> X-Ray (and Medical Report) <input type="checkbox"/> Muscle Power Tests (Scale 0-5) <input type="checkbox"/> Biopsy  Other _____

Impaired passive range of movement (pROM)

- Arthrogyposis
- Joint contractures
- Trauma

Other \_\_\_\_\_

- Medical Report)
- X-Ray (and Medical Report)
- Photographs
- Goniometric measures of joint limitations.

Limb Deficiency and/or Limb Length Difference

- Trauma
- Dysmelia
- Traumatic amputation
- Bone cancer

Other \_\_\_\_\_

- Medical Report)
- X-Ray (and Medical Report)
- Photographs

Other \_\_\_\_\_

Short Stature

- Achondroplasia
- Osteogenesis imperfecta
- growth hormone dysfunction

Other \_\_\_\_\_

- Medical Report)
- X-Ray (and Medical Report)
- Photographs

Other \_\_\_\_\_

Coordination impairment

- Ataxia
- Dyskinesia (athetosis, Dystonia, chorea)
- Hypertonia/spasticity

- Cerebral Palsy
- Traumatic brain injury
- Multiple Sclerosis
- Stroke

Other \_\_\_\_\_

- Medical Report)
- Modified Ashworth Scale
- Cerebral MRI or TC Scan

Other \_\_\_\_\_

### Medical History:

**Athlete's condition is:**    Stable    Progressive    Fluctuating    Permanent

**Age of onset:** \_\_\_\_\_ Years    Congenital

**Current: treatments:** \_\_\_\_\_

**Past Treatment:** \_\_\_\_\_

**Anticipated future treatment:** \_\_\_\_\_

**Additional details on medical diagnosis (if required):**

**Medications and reason for prescription**

**Presence of additional medical conditions/diagnoses**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> Vision impairment       | <input type="checkbox"/> Impaired respiratory function        | <input type="checkbox"/> Joint<br>Hypermobility/instability             |
| <input type="checkbox"/> Intellectual impairment | <input type="checkbox"/> Impaired metabolic functions         | <input type="checkbox"/> Impaired muscle endurance<br>(Chronic fatigue) |
| <input type="checkbox"/> Hearing impairment      | <input type="checkbox"/> Impaired cardiovascular<br>functions | Other _____   |
| <input type="checkbox"/> Psychological diagnoses | <input type="checkbox"/> Pain                                 |   |

**Describe:**

**Certification:**

I confirm that the information provided is accurate and has not been edited or altered in any way.

Name: \_\_\_\_\_

**Medical Speciality:** \_\_\_\_\_

**Medical Registration Number:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_

**Country:** \_\_\_\_\_

**Phone:** \_\_\_\_\_

**E-mail:** \_\_\_\_\_

**Date:** \_\_\_\_\_

**Signature:** \_\_\_\_\_