INSTRUCTION

Medical **D**iagnostic **F**orm
For athletes with Neurological impairments

WORLD PARA TAEKWONDO

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.

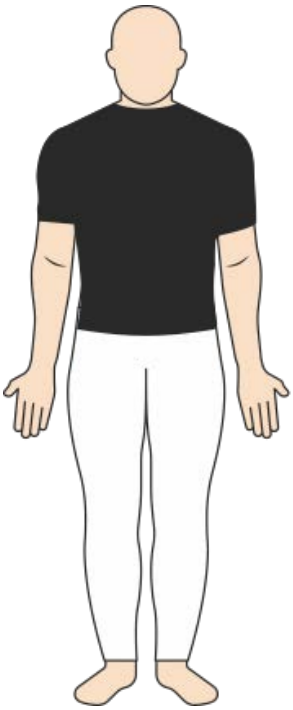
- The Assessment group may ask for further documents to be submitted depending on the individual athlete's health condition and impairment.

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

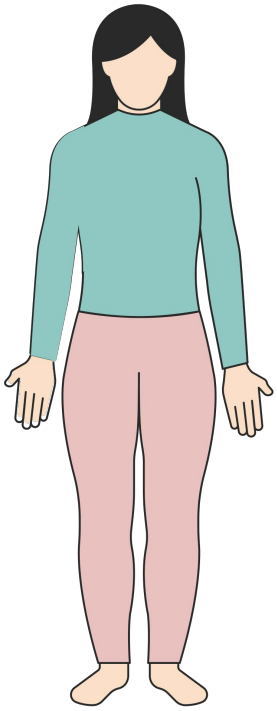
PHOTO GUIDE

Medical **D**iagnostic **F**orm
For athletes with Neurological impairments

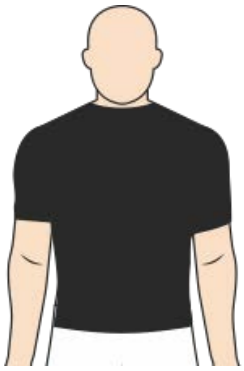
WORLD PARA TAEKWONDO



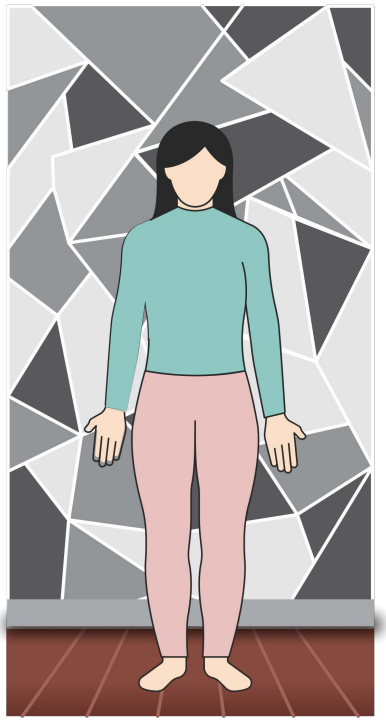
Anatomical position & full body photo ✓



Clear background ✓



Part body photo ✗



Background ✗

MDF

Medical Diagnostic Form

For athletes with Neurological impairments

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 ☐ Ataxia

Underlying Health Condition:

☐ Brain injury ☐ Brain stroke ☐ Spinal cord injury ☐ Cerebral Palsy

Others, specify:	

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

Which condition / Which limb(s) affected / degree of Severity:		
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: