

**MEDICAL DIAGNOSTIC FORM
ATHLETES WITH PHYSICAL IMPAIRMENT**

ARCHERY NEW ZEALAND

Classification is integral to Para sport as it provides the structure for fair and equitable competition within the Paralympic Movement. Classification performs two critical functions:

1. The determination of which athletes are eligible to compete in Para sport; and
2. The grouping of eligible athletes into Sport Classes is based on the extent to which their impairment(s) impact(s) their ability to execute the specific tasks and activities fundamental to the relevant sport.

To be eligible for Para sport, an athlete must have (or has had) at least one medically and/or clinically diagnosed Underlying Health Condition which aligns to one or more recognised permanent Eligible Impairment types.

For eligibility to be assessed, please ensure this form is completed in full and the requested medical information is provided. If eligibility is identified, a Provisional (or temporary) Sport Class will be allocated as per individual Para sport Classification rules, or until an Athlete Evaluation is conducted in-person by a Classification Panel.

Please email the completed form and medical information to para@archery.org.nz.

ATHLETE INFORMATION (TO BE COMPLETED BY THE ATHLETE)

Surname	
First Name(s)	
Gender	
Date of Birth	
Address	
Email	
Contact Number	

MEDICAL INFORMATION (TO BE COMPLETED BY A REGISTERED MEDICAL DOCTOR)

Athletes Medical Diagnosis (Health Condition):			
Description of body part/s affected and limitations to activity:			
Primary Impairment/s arising from the Medical Diagnosis (Health Condition):			
<input type="checkbox"/> Impaired muscle power		<input type="checkbox"/> Ataxia	<input type="checkbox"/> Leg length difference
<input type="checkbox"/> Impaired passive range of motion		<input type="checkbox"/> Athetosis	<input type="checkbox"/> Short stature (height:_____ cm)
<input type="checkbox"/> Limb deficiency/loss		<input type="checkbox"/> Hypertonia	

Health condition is: <div style="display: flex; justify-content: space-around; align-items: center;"> <input type="checkbox"/> Permanent <input type="checkbox"/> Stable <input type="checkbox"/> Progressive <input type="checkbox"/> Fluctuating </div>				
Health condition is: <div style="display: flex; justify-content: space-around; align-items: center;"> <input type="checkbox"/> Acquired <input type="checkbox"/> Congenital (birth) </div>				
Year of onset:				
Diagnostic Evidence to be attached: <p>Evidence to support the above Health Condition MUST be attached:</p> <div style="display: flex; justify-content: space-around; align-items: flex-start;"> <input type="checkbox"/> Medical Diagnostic Report and Physical Examination Results (for example: ASIA scale for Athletes with Spinal Cord Injury; Manual Muscle Power Test Score for Athletes with impaired muscle power; Range of Movement Score for Athletes with impaired range of movement; Ashworth Scale for Athletes with a neurological impairment; X-rays for Athletes with dysmelia; photo for Athletes with amputation) <input type="checkbox"/> Report(s) from additional diagnostic testing, where appropriate (for example, EMG, MRI, CT) </div>				
Treatment History:				
Regular Medication (List dosage and reason):				
Presence of additional medical conditions/diagnoses: <div style="display: flex; justify-content: space-between; align-items: flex-start;"> <div style="flex: 1;"> <input type="checkbox"/> Vision impairment <input type="checkbox"/> Intellectual impairment <input type="checkbox"/> Hearing impairment <input type="checkbox"/> Psychological diagnoses </div> <div style="flex: 1;"> <input type="checkbox"/> Impaired respiratory function <input type="checkbox"/> Impaired metabolic functions <input type="checkbox"/> Impaired cardiovascular functions <input type="checkbox"/> Pain </div> <div style="flex: 1;"> <input type="checkbox"/> Joint Hypermobility/ instability <input type="checkbox"/> Impaired muscle endurance (e.g., Chronic fatigue) <input type="checkbox"/> Other: _____ </div> </div>				
Describe:				
Medical Declaration (to be completed by a registered Medical Doctor)				
<input type="checkbox"/> I confirm that the above information is accurate				
Doctors Name:				
Medical Specialty:			Registration Number:	

Address:	
City:	
Phone:	
Signature:	
Country:	Email:
Date:	

ATHLETE INFORMATION (TO BE COMPLETED BY THE ATHLETE)

Are you able to walk?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Do you use crutches or a mobility aid?	<input type="checkbox"/> Yes <input type="checkbox"/> No Type:
Are you a full-time wheelchair user?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Number of years involved in the sport	
Do you train with a coach?	
Number of training sessions per week	
Number of competitions in the past 12 months	
Do you compete:	
➤ Seated (wheelchair user)	<input type="checkbox"/> Yes <input type="checkbox"/> No
➤ Standing (ambulant)	<input type="checkbox"/> Yes <input type="checkbox"/> No

ATHLETE DECLARATION

I declare the information submitted on this form to be a true and accurate reflection of my sporting history.

I understand that failure to give accurate information may result in me receiving an incorrect Sports Class.

I understand that I will receive a Provisional Classification according to the information that I submit to Archery New Zealand on this form. I understand that information from this classification form will be held by Archery New Zealand who may share this information with other Regional, National and International organisations that are involved in my sport development.

I agree to having my photo taken and/or a video taken to support information for Classification purposes.

Signature of Athlete
(or guardian if under 18)

Date

For further information on Classification contact:

Please email this form back to:
Archery New Zealand
para@archery.org.nz