U.S. PARALYMPICS POWERLIFTING

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National Level Para Powerlifting
Medical Diagnostic Form for All Athletes with Physical Impairment

To be eligible for Para powerlifting an athlete must have an underlying medical diagnosis (Health Condition) that results in a Permanent and Eligible Impairment (article 7 in the World Para Powerlifting Classification Rules and Regulations). The measurement of impairment conducted during the classification process must correspond to the diagnosis indicated below.

Athlete Information

Family name:			
Given name/s:			
Gender:	❑ Female ❑ Male	**Date of Birth:**	(dd/mm/yyyy)

Medical Information (to be completed in English by a licensed Medical Doctor or if completed by a parent/guardian must be accompanied by a letter from a Medical Doctor verifying the Athlete's Underlying Health Condition and primary impairment as described below)

Athlete's Medical Diagnosis (Health Condition):	
Include description of body part/s affected and limitations:	

Primary Impairment/s arising from the Medical Diagnosis (Health Condition):

❑ Impaired muscle power	❑ Ataxia	❑ Leg length difference
❑ Impaired passive range of motion	❑ Athetosis	❑ Limb deficiency/loss
	❑ Hypertonia	❑ Short stature (height:_____cm)

Medical condition is:	❑ Permanent	❑ Stable	❑ Progressive	❑ Fluctuating
Year of onset:	(yyyy)	❑ Congenital (birth)		

Diagnostic Evidence to be Attached:
Evidence to support the above diagnosis must be attached in English for all athletes:

- ❑ Medical Diagnostic Report and Physical Examination results (for example ASIA scale for Athletes with Spinal Cord Injury, Ashworth Scale for Athletes with Cerebral Palsy, X-rays for Athletes with dysmelia, photo for Athletes with amputation)

- ❑ Report(s) from additional diagnostic testing (for example, EMG, MRI, CT, X-ray)

Treatment History:

Regular Medication – List dosage and reason:

Presence of additional medical conditions/diagnoses:

- ❑ Vision impairment
- ❑ Intellectual impairment
- ❑ Hearing impairment
- ❑ Psychological diagnoses
- ❑ Impaired respiratory function
- ❑ Impaired metabolic functions
- ❑ Impaired cardiovascular functions
- ❑ Pain
- ❑Joint Hypermobility/ instability
- ❑ Impaired muscle endurance (e.g., Chronic fatigue)
- ❑ Other: ___________________

Describe:

❑ **I confirm that the above information is accurate**

If completed by Medical Doctor:			
Doctor Name:			
Medical Specialty:		**Registration Number:**	
Address:			
City:		**Country:**	
Phone:		**E-mail:**	
Signature:		**Date:**	

If completed by Parent/Guardian (letter from medical doctor must be attached):			
Parent/Guardian Name:			
Address:			
City:		**Country:**	
Phone:		**E-mail:**	
Signature:		**Date:**	