

Medical Diagnostics Form for athletes with physical impairment

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

The completed form with attached medical documentation must be uploaded to the athlete's profile upon registration of the athlete to the UIPM license system. This applies for all athletes with physical impairment competing in Para Pentathlon and/or any of its sub-sports.

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, UIPM retains the right to request further information. In absence of such information, the athlete will not be able to proceed with Athlete Evaluation.

Athlete Information (to be filled in by the NPC):

Family name:			
Given name:			
Gender:		Date of Birth:	
NPC:		UIPM License ID:	
<input type="checkbox"/> the athlete's sport class status is NEW <input type="checkbox"/> the athlete's sport class status is REVIEW			

Medical information

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

Eligible impairment (tick)	Medical diagnosis relevant to impairment type (tick or add)	Documents to support the diagnosis (tick or add)
<input type="checkbox"/> Limb deficiency	<input type="checkbox"/> Dismelia <input type="checkbox"/> Traumatic amputation <input type="checkbox"/> Bone Cancer <input type="checkbox"/> Other: _____	<input type="checkbox"/> Medical report <input type="checkbox"/> X-rays <input type="checkbox"/> Photographs <input type="checkbox"/> Other: _____
<input type="checkbox"/> Impaired passive range of movement	<input type="checkbox"/> Arthrogyrosis <input type="checkbox"/> Joint Contractures <input type="checkbox"/> Trauma <input type="checkbox"/> Other: _____	<input type="checkbox"/> Medical report <input type="checkbox"/> X-rays <input type="checkbox"/> Photographs <input type="checkbox"/> Goniometric measures of joint limitations <input type="checkbox"/> Other: _____
<input type="checkbox"/> Leg length difference	<input type="checkbox"/> Trauma <input type="checkbox"/> Dismelia <input type="checkbox"/> Other: _____	<input type="checkbox"/> Medical report <input type="checkbox"/> X-rays <input type="checkbox"/> Photograph <input type="checkbox"/> Other: _____
<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 <input type="checkbox"/> Other: _____	<input type="checkbox"/> Medical report <input type="checkbox"/> ASIA scale <input type="checkbox"/> Electromyography <input type="checkbox"/> MRI <input type="checkbox"/> X-Rays <input type="checkbox"/> Biopsy <input type="checkbox"/> Other: _____

Medical history:

Athlete's condition is:	<input type="checkbox"/> Stable	<input type="checkbox"/> Progressive	<input type="checkbox"/> Fluctuating	<input type="checkbox"/> Permanent
Age of onset:				<input type="checkbox"/> Congenital
Past treatments:				
Current treatments:				
Anticipated future treatments:				



UIPM

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de Pentathlon Moderne

Additional details on medical diagnosis (if needed):

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Medication and reason for prescription:

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I confirm that the above information is accurate.

Name:

Medical specialty:

Registration number:

Address:

City:

Country:

Phone:

E-mail:

Date :

Signature

Stamp:

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