



### Medical Assessment Form for Wheelchair Athletes

To be eligible for The Karatedo Federation of Hong Kong, China Limited (“KFHKCL”) an athlete must have an underlying medical assessment (Health Condition) that results in a permanent and eligible impairment. The measurement of impairment conducted during the classification process must correspond to the assessment indicated below.

**It must be completed by a registered \* Medical Doctor, M.D / Physiotherapist.**

The KFHKCL holds the right to request further information, if additional information is required. The athlete will not be able to undergo classification, until the requested information is provided.

### Athlete Information

<b>Family name:</b>	
<b>Given name/s:</b>	
<b>Gender:</b> <input type="checkbox"/> <b>Female</b> <input type="checkbox"/> <b>Male</b>	<b>Date of Birth:</b> (dd/mm/yyyy)

**Medical Information** – to be completed in **English** by a registered \* Medical Doctor, M.D / Physiotherapist.

<b>Athlete's Medical Assessment (Health Condition):</b>	
<b>Include description of body part/s affected and limitations:</b>	
<b>Primary Impairment/s arising from the Medical Assessment (Health Condition):</b> <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"/> Limb deficiency/loss <input type="checkbox"/> Hypertonia	
<b>Medical condition is:</b> <input type="checkbox"/> Permanent <input type="checkbox"/> Stable <input type="checkbox"/> Progressive <input type="checkbox"/> Fluctuating	
<b>Year of onset:</b> (yyyy)	<input type="checkbox"/> Congenital (birth)

**\* Please delete as appropriate**



<b>Diagnostic Evidence to be attached:</b> <input type="checkbox"/> Evidence to support the above assessment <b>MUST</b> be attached in <b>English</b> for <b>ALL</b> athletes: Medical Assessment Report and Physical Examination results (for example ASIA scale for Athletes with Spinal Cord Injury, Modified Ashworth Scale for Athletes with Cerebral Palsy, X-rays for Athletes with dysmelia, photo for Athletes with amputation)  The KFKHCCL holds the right to request additional assessment evidence including but not limited to: <input type="checkbox"/> Report(s) from additional assessment testing (for example EMG, MRI, CT, X-ray)														
<b>Treatment History:</b>  														
<b>Regular Medication – List dosage and reason:</b>  														
<b>Presence of additional medical conditions/assessment:</b> <table style="width: 100%; border: none;"> <tr> <td style="width: 33%; border: none;"><input type="checkbox"/> Vision impairment</td> <td style="width: 33%; border: none;"><input type="checkbox"/> Impaired respiratory function</td> <td style="width: 33%; border: none;"><input type="checkbox"/> Joint Hypermobility/instability</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Intellectual impairment</td> <td style="border: none;"><input type="checkbox"/> Impaired metabolic functions</td> <td style="border: none;"><input type="checkbox"/> Impaired muscle endurance (e.g., Chronic fatigue)</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Hearing impairment</td> <td style="border: none;"><input type="checkbox"/> Impaired cardiovascular functions</td> <td style="border: none;"><input type="checkbox"/> Other: _____</td> </tr> <tr> <td style="border: none;"><input type="checkbox"/> Psychological diagnoses</td> <td style="border: none;"><input type="checkbox"/> Pain</td> <td></td> </tr> </table> <p style="margin-top: 5px;">Please describe:</p>			<input type="checkbox"/> Vision impairment	<input type="checkbox"/> Impaired respiratory function	<input type="checkbox"/> Joint Hypermobility/instability	<input type="checkbox"/> Intellectual impairment	<input type="checkbox"/> Impaired metabolic functions	<input type="checkbox"/> Impaired muscle endurance (e.g., Chronic fatigue)	<input type="checkbox"/> Hearing impairment	<input type="checkbox"/> Impaired cardiovascular functions	<input type="checkbox"/> Other: _____	<input type="checkbox"/> Psychological diagnoses	<input type="checkbox"/> Pain	
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<input type="checkbox"/> I confirm that the above information is accurate <b>* Medical Doctor, M.D / Physiotherapist Name:</b> 	
<b>Medical Specialty:</b>	<b>Registration Number:</b>
<b>Address:</b>	
<b>Phone:</b>	<b>E-mail:</b>
<b>Signature:</b>	<b>Date:</b>

**Please, send this document as a PDF to the KFKHCCL.**

**\* Please delete as appropriate**