



Form 1 – Para Badminton Medical Information Form

Note: This form is for players seeking classification for competition and must be filled together with the doctor who can provide the medical information relating to the player's disabilities. All information provided will be treated as CONFIDENTIAL.

Please provide copies of any medical diagnosis (for example, medical imaging, X-rays etc).

Limitations due to pain are not considered for classification if that is the only condition.

For submission: Please type on this form – and when completed, print out and sign. Scan the form into .pdf file(s) and send it to sports@paralympic.org.my at least six (6) weeks before the tournament. Please also bring the original form along to the classification process.

Tournament Details (To be filled by the player / coach)	
Name of Tournament (Tournament you are participating)	
Proposed Sport Class at Entry (Please circle only one)	WH 1 / WH 2 / SL 3 / SL 4 / SU 5 / SH 6

Players Details (To be filled by the player / coach)			
Last Name			
First Name			
Nationality / State (as stated in passport)			
Member Association (organisation you represent in Para badminton)			
Date of Birth (DD/MM/YYYY)		Gender (M / F)	

Player's Declaration and Acknowledgment

I, _____, declare that all the information included in this Form 1 is, to the best of my knowledge, a true and accurate record of my circumstances:

Signature		Date (DD/MM/YYYY)	
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If the player has a legal guardian (as a minor or otherwise), please also include guardian's name, signature, and relation to player.



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Medical Diagnosis (To be filled by doctor)
***Please refer to page 4 for required supporting documents**

Please provide brief details of the medical diagnosis. Include dates and details of anything which affects the body's MOTOR functions such as congenital conditions, spinal cord injuries / diseases, head injuries, neurological conditions, amputation of limbs, peripheral nerve lesions; or joint arthrodesis.

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Are there any additional impairments? (Scoliosis, arthrodesis, spasticity, etc.)

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Operations in the Past (To be filled by doctor)

List the operations undergone in the past

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Current Medications (To be filled by doctor / player / coach)

List the medications currently taking (name the substance – not the medicaments name). The player and coach are advised to refer to current [WADA Prohibited List](#) and submit TUE form if needed.

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Doctor's Details (To be filled and signed by doctor)					
Full Name					
Professional Address	<table border="1" style="width: 100%;"> <tr> <td style="width: 60%;">Postal Address:</td> <td style="width: 40%;">Official Stamp:</td> </tr> <tr> <td></td> <td>Signature:</td> </tr> </table>	Postal Address:	Official Stamp:		Signature:
Postal Address:	Official Stamp:				
	Signature:				
Contact Details	<table border="1" style="width: 100%;"> <tr> <td style="width: 60%;">Mobile Number:</td> <td style="width: 40%;"></td> </tr> <tr> <td>Email Address:</td> <td></td> </tr> </table>	Mobile Number:		Email Address:	
Mobile Number:					
Email Address:					
Date of Examination (DD/MM/YYYY)					
Place of Examination					



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Medical Diagnosis and Supporting Documents

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

Eligible Impairment (tick as appropriate)	Name of the medical diagnosis relevant to impairment type (tick or add as appropriate)	Documents to support the diagnosis (tick/add as appropriate, and submit with this form)
Impaired muscle power	<ul style="list-style-type: none"> • Spinal cord injury • Muscular dystrophy • Spina bifida • Polio myelitis • Multiple sclerosis • Other: _____ 	<ul style="list-style-type: none"> • Medical report • ASIA scale • Electromyography • MRI • X-rays • Biopsy • Other: _____
Impaired passive range of motion	<ul style="list-style-type: none"> • Arthrogyposis • Joint contractures • Trauma • Other: _____ 	<ul style="list-style-type: none"> • Medical report • X-rays • Photographs • Goniometric measures of joint limitations
Ataxia Athetosis Hypertonia	<ul style="list-style-type: none"> • Cerebral palsy • Traumatic brain injury • Multiple sclerosis • Stroke • Other: _____ 	<ul style="list-style-type: none"> • Medical report with neurological examination • Cerebral MRI or TC scan • Other: _____
Leg length difference	<ul style="list-style-type: none"> • Trauma/dysmelia • Other: _____ 	<ul style="list-style-type: none"> • Medical report • X-rays • Photograph • Other _____
Short stature	<ul style="list-style-type: none"> • Achondroplasia • Osteogenesis imperfecta growth hormone dysfunction • Other: _____ 	<ul style="list-style-type: none"> • Medical report • X-rays • Photograph • Other _____
Limb deficiency	<ul style="list-style-type: none"> • Dysmelia • Traumatic amputation • Bone cancer • Other: _____ 	<ul style="list-style-type: none"> • Medical report • X-rays • Photographs • Other _____
Scoliosis	<ul style="list-style-type: none"> • Idiopathic scoliosis • Congenital scoliosis • Neuromuscular scoliosis • Other: _____ 	<ul style="list-style-type: none"> • Medical report • X-rays (Spinal x-ray with Cobb angle) • Photographs • Other: _____



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Wheelchair Category Questionnaire

(Please mark "X" in the given brackets)

This questionnaire must be completed by new players in wheelchair category. **The answers must also be confirmed truthful by the doctor and the team manager/coach.**

*** The player MUST bring the assistance device(s) to classification.**

Wheelchair Category Questionnaire			
1.	Do you totally depend on wheelchair for mobility?	NO ()	YES ()
If you answered No to Question 1, please answer the following questions:			
2.	How do you walk in your house?	Without assistive device YES () NO ()	Do you have a limping gait? (e.g. walk with a limp) a) None () b) Mild () c) Moderate () d) Severe ()
		With assistive device YES () NO ()	State the device(s): (Tick all relevant) a) Prosthesis () b) Calliper/Brace () c) Crutches () d) Others (please state) _____ _____



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3.	<p>How do you walk outside your house?</p> <p>(Example: going around your house, going to school, shopping or working place, etc.)</p>	<p>Without assistive device</p> <p>YES ()</p> <p>NO ()</p>	<p>Do you have a limping gait? (e.g. walk with a limp)</p> <p>a) None ()</p> <p>b) Mild ()</p> <p>c) Moderate ()</p> <p>d) Severe ()</p>
		<p>With assistive device</p> <p>YES ()</p> <p>NO ()</p>	<p>State the device(s): (Tick all relevant)</p> <p>a) Prosthesis ()</p> <p>b) Calliper/Brace ()</p> <p>c) Crutches ()</p> <p>d) Others (please state)</p> <p>_____</p> <p>_____</p>
4.	<p>Could you run on the badminton court?</p>	<p>NO ()</p>	<p>YES ()</p> <p>a) Easy ()</p> <p>b) Slight difficulty ()</p> <p>c) Moderate difficulty ()</p> <p>d) Extreme difficulty ()</p>
5.	<p>Special notes about the player's disability that justify his/her use of wheelchair for badminton. (Example: Past medical history, current medical problems, further evidence etc.)</p>		



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Declaration

By signing below, I confirm that the answers to the above questionnaire are accurate and truthful to the best of my knowledge.

Player	Manager / Coach	Doctor
<p>Signature:</p> <p>Full Name:</p> <p>Date: (DD/MM/YYYY)</p>	<p>Signature:</p> <p>Full Name:</p> <p>Date: (DD/MM/YYYY)</p>	<p>Signature:</p> <p>Full Name:</p> <p>Date: (DD/MM/YYYY)</p>