# PARA VA'A COMPREHENSIVE PADDLER MEDICAL DIAGNOSIS FORM

**IMPORTANT INSTRUCTIONS:**

This form must be completed entirely in **English**.

**Section 1 & 2** are to be filled out by the paddler.

**Section 3, 4 & 5 MUST** be completed and signed by a licensed **Medical Doctor**.

This form must be submitted to undergo classification for international competition.

## SECTION 1: PADDLER PERSONAL DETAILS (To be completed by paddler)

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**Family Name/Last Name (as per passport):** _____

**Given Name/First Name (as per passport):** _____

**Preferred Name (to be called by):** _____

**Date of Birth (MM/DD/YYYY):** _____ / _____ / _____

**Sex:** ☐ Male (M) ☐ Female (F)

**Paddler Address:** _____

**Country:** _____

## SECTION 2: PADDLER DECLARATION OF MEDICAL COMPLICATIONS & EMERGENCY MEASURES (To be completed by paddler)

I wish to compete in IVF events. I understand that the IVF requires me to state any known medical conditions that may compromise my safety on the water. I understand that I must state the current management for my condition(s).

**Possible Medical Complications that could occur on water:**

_____

_____

_____

**Steps to take should these complications occur:**

_____

_____

_____

**All current medications are as follows:**

_____

_____

_____

**Data Protection & Privacy Notice**

The International Va'a Federation (IVF) acts as the data controller for the personal and medical data collected on this form. By signing below, you acknowledge that your identity, contact, paddler profile, and highly sensitive medical/classification details will be processed to manage paddler registration, competition eligibility, anti-doping compliance, and international classification. This data may be shared with national member federations, classification panels, event organizers, and anti-doping authorities (such as WADA). Your data is protected by security measures and retained only as long as necessary for historical sporting records and legal compliance.

Please tick the following:

☐ I have read, understood, and agree to the full IVF Data Privacy Policy available online and consent to the processing and transfer of my personal and medical data for these purposes.



**Paddler Family Name:** _____

**Paddler Name (Print):** _____

**Paddler Signature:** _____

**Date (MM/DD/YYYY):** _____ / _____ / _____

*Required if the paddler is under 18 years of age:*
**Parent/Guardian Name (Print):** _____

**Parent/Guardian Signature:** _____

**Date (MM/DD/YYYY):** _____ / _____ / _____

**Print Witness Name:** _____

**Witness Signature:** _____

**Date (MM/DD/YYYY):** _____ / _____ / _____

*(Parent/Guardian signature required if the paddler is under 18 years of age)*

## SECTION 3: MEDICAL DIAGNOSIS & IMPAIRMENT DETAILS (To be completed by a Medical Doctor)

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**Primary Medical Diagnosis:**

_____

_____

**How long has the paddler had this condition?** _____

**Condition Status (Tick one):** ☐ Stable ☐ Deteriorating / Progressive ☐ Fluctuating

**Physical Impairment Categories (Tick all that apply):**

☐ **Amputee**

*Affected Limb(s)* ☐ Left ☐ Right ☐ Both

*Level:* ☐ Above knee ☐ Below knee

☐ **Coordination Impairment (Neurological)**

☐ Monoplegia ☐ Diplegia ☐ Hemiplegia ☐ Quadriplegia

☐ Ataxia ☐ Athetosis

☐ **Spinal Cord Injury / Spina Bifida**

*Level of Injury:* _____

☐ Complete ☐ Incomplete

☐ Autonomic Dysreflexia Risk

☐ **Polio**

☐ **HSMN (Charcot-Marie-Tooth / CMT)**

☐ **Other Impairment:** _____

## SECTION 4: RELEVANT MEDICAL HISTORY & ASSOCIATED CONDITIONS (To be completed by a Medical Doctor)

Please check any secondary conditions or medical history factors that may affect the paddler's fitness for competitive sports or safety on the water:

| | |
|---|---|
| [ ] Asthma ☐ | [ ] High Blood Pressure (Hypertension) ☐ |
| [ ] Cancer ☐ | [ ] Stroke ☐ |
| [ ] Diabetes ☐ | [ ] Seizures / Epilepsy ☐ |
| [ ] Dehydration Risk ☐ | [ ] Communication Disorder ☐ |
| [ ] Heart Disease ☐ | [ ] Severe Allergies (Specify below) ☐ |

**Severe Allergies (Please specify allergy):**_____

_____

_____

**Other Conditions:** _____

**Paddler Mobility Status:**

☐ Independent walker
☐ Uses orthotic aids
☐ Uses crutches / walking sticks
☐ Wheelchair user



**Paddler Family Name:** _____

## SECTION 5: MEDICAL DOCTOR'S DECLARATION & SIGNATURE

I hereby certify that I have known this patient for _____ years and certify that the above named patient has the stated diagnosis and that the information provided in Sections 3, 4, and 5 is accurate to the best of my medical knowledge.

**Doctor's Name (Please Print):** _____

**Doctor's Signature:** _____

**Date (MM/DD/YYYY):** _____ / _____ / _____

**Medical Practice Address:** _____

_____

_____

**Telephone:**_____

**Email:** _____