



Part: 1 Para Archery National Classification Medical Intake Form

This form consists of three parts.

The first part is a request form which needs to be completed and signed by a USA Archery representative. The second part is the consent form which must be signed by the athlete to allow the Classifiers to collect their personal data. The third part is the Medical Intake form that provides evidence of the relative health condition and needs to be completed by a physician familiar with the applicant's medical condition, disease, or injury and who must sign the completed document and provide national medical society or board of practice information for verification purposes. All parts must be completed electronically in the *English language* and received by USA Archery (para@usarchery.org) 30 days prior to the classification.

As this form represents the first step in the classification process, the information provided must be honest, accurate, and verifiable. Successful completion of this form does not indicate that a classification will be performed. Rather, it provides a concise basis of discussion between the applicant and classification team regarding the applicant's potential for being successfully classified as a para archery competitor. If the form has not been completed in all three parts, it will be returned to the National Organization.

The information provided on this form is essential to verify that the medical condition, disease, or injury that the applicant has sustained has a clear impact on their ability to function in the sport of archery.

An electronic portrait picture (passport type, JPG) is required together with this form as a separate attachment.

Archer Details: The archer must bring with them evidence of their medical condition in English.
The archer must also bring all special equipment & assistive devices to the classification.
<u>appointment.</u>
Last Name _____
First Name _____
Date of birth (DD/MM/YYYY) _____
Country _____
Type of request (cross only one type of request) new classification <input type="checkbox"/> review with the fixed date <input type="checkbox"/>
reclassification <input type="checkbox"/>

Date _____ Place _____

Signature of USA Archery Representative _____



Part 2: Consent Form

The archer agrees to cooperate fully with the classification:

- By fully answering all questions truthfully.
- Attempting all physical tests to the best of their ability.

Note: Athletes who do not cooperate fully as stated above may be disqualified from the competition.

In agreeing to be classified, the archer must understand that some of the tests may unfortunately cause pain. We are sorry for this, but it is unavoidable.

Consent and Athlete Declaration

I have no health problems which would stop me undertaking the tests ask of me.

I agree that if I sustain an injury during the classification procedure I hold Para archery blameless.

My participation in the classification procedure is voluntary and I have the right to withdraw at any time. If I withdraw I understand that classification cannot take place and I will not be able to compete in Para archery competitions.

To assist USA Archery in developing the classification system, I also give my consent to allow data collected during my classification to be used for research and educational purposes. This includes any photographs or videos taken during the field evaluation component of classification and/or training and competition. I understand that I may withdraw this consent at any time.

Archer's Signature: _____

Date: _____



Part 3 - Para Archery Classification Medical Information Intake Form

Applicant Information

First and Last Name name (as passport)	
Date & Place of Birth (DD/MM/YYYY)	
National Governing Body (Member Association)	USA Archery
<i>This part is filled only if reclassification is requested</i> Reason of the reclassification request (<i>explain the change of the eligibility according to previous</i>) classification)	
Primary Diagnosis (the major medical condition, disease, or injury that impacts the applicant's ability to perform the sport of archery)	
Date of diagnosis (DD/MM/YYYY)	
Significant functional limitations and/or impairments associated with the Primary Diagnosis	
Summary of Special Tests that confirm the Primary Diagnosis (may include information provided by X-rays, Magnetic Resonance Images, Diagnostic Electromyography, or other tests deemed appropriate by a treating physician)	



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<p>Secondary Diagnosis (a secondary medical condition, disease, or injury that when combined with the primary medical diagnosis impacts the applicant's ability to perform the sport of archery)</p>	
<p>Date of diagnosis (DD/MM/YYYY)</p>	
<p>Significant functional limitations and/or impairments associated with the Secondary Diagnosis</p>	
<p>Summary of Special Tests that confirm the Secondary Diagnosis (may include information provided by X-rays, Magnetic Resonance Images, Diagnostic Electromyography, or other tests deemed appropriate by a treating physician)</p>	
<p>Any other medical conditions, diseases, injuries, or extenuating circumstances that may impact the applicant's ability to perform the sport of archery</p>	



Para Archery Classification Medical Information Intake Form

Physician Information

First and Last Name	
Signature	
Physician National Medical Society or National Board of Practice	
Physician Registration Number	