

ADAPTIVE PADDLING CLASSIFICATION APPLICATION FORM

LAST NAME _____ FIRST NAME _____

Sex _____ Date of Birth (mo/day/yr) _____

Address _____

IVF Member _____

Please attach the following documentation as appropriate to the application:

- 1. IVF Adaptive Paddling Vision Qualification Form signed by an Ophthalmologist or Optometrist.
- 2. IVF Certificate of Medical Diagnosis signed by a medical doctor.

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FOR CLASSIFIERS USE ONLY

DIAGNOSIS + ASSOCIATED DIAGNOSIS + COMMENTS:

Visual Impairment _____

Physical Disability

Amputee _____ Level _____

Spinal Level Impaired _____ Complete/Incomplete Since _____

Cerebral Palsy _____

Other _____

Documentation of Disability Attached _____

Progressive: Yes/No

Seizures: Yes/No

Asthma: Yes/No

Ability to Walk: Yes/No

Crutches: Yes/No

Wheelchair: Yes/No

Testing Place & Date _____ Recommended Class: 1 2 3 4 5

Classifiers Comment _____

Signature, IVF Classifier (Medical)

Signature, IVF (Technical)

Signature, Paddler

Print Name IVF Member

Print Name IVF Member

Print Name IVF Member

Date and Time Athlete Informed of Classification _____