



**U.S. PARALYMPICS  
CONSENT FORM FOR VISUAL IMPAIRMENT CLASSIFICATION**

**Explanation:**

For an athlete to be eligible to compete in U.S. Paralympics competitions the athlete must be classified by classifiers appointed by the NPC (National Paralympic Committee) or the IPC (International Paralympic Committee) / Sport IF (International Federation).

Failure to cooperate with the classifiers or failure to complete a classification may lead to ineligibility to compete in U.S. Paralympics or IPC/IF approved/sanctioned competition.

The following is an agreement by the athlete to undergo the testing procedure.

I \_\_\_\_\_ (**printed name of the athlete**) wish to be classified on national level for U.S. Paralympics competition.

I understand that the classification process involves the necessary eye tests. I understand that to be classified I must be willing to take part in all portions of the testing procedure and cooperate fully with the classifiers / optometrist / ophthalmologist.

**Signature of Athlete:** \_\_\_\_\_

**Witness Signature:** \_\_\_\_\_

*\*\*Must be parent/guardian if athlete is under age 18\*\**

**Date and Location:** \_\_\_\_\_

Send completed forms to Bryce Boarman at [Bryce.Boarman@usoc.org](mailto:Bryce.Boarman@usoc.org) or by fax at 719-866-2029.

# Medical Diagnostics Form for athletes with Vision Impairment

The form is to be completed in English and by a registered ophthalmologist.

All medical documentation required on pages 2-3 needs to be attached.

The form and the attached medical documentation may not be older than 12 months at the time of the Athlete Evaluation.

## Athlete Information

Last name: \_\_\_\_\_

First name: \_\_\_\_\_

Gender: Female  Male  Date of Birth: \_\_\_\_\_

Sport: \_\_\_\_\_ IF registration ID

NPC/NF: \_\_\_\_\_ (if applicable): \_\_\_\_\_

## Medical Information

Diagnosis:

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Medical history:

Age of onset: \_\_\_\_\_

Anticipated future procedure(s): \_\_\_\_\_

Athlete wears  yes  no Correction: Right: \_\_\_\_\_

glasses: Left: \_\_\_\_\_

Athlete wears  yes  no Correction: Right: \_\_\_\_\_

contact lenses: Left: \_\_\_\_\_

Athlete wears eye  right  left

prosthesis:

Medication:

Eye medications used by the athlete:	
Ocular drug allergies:	

Athlete: \_\_\_\_\_

**Assessment of visual acuity and visual field**

Visual Acuity

	Right eye	Left eye
With correction		
Without Correction		

Type of correction: \_\_\_\_\_

Measurement Method: \_\_\_\_\_

Visual Field:

In degrees (diameter)	Right eye	Left eye

**Attachments to the Medical Diagnostic Form**

**1. Visual field test**

For all athletes with a restricted visual field a visual field test must be attached to this form. The athlete’s visual field must be tested by full-field test (120 degrees) and a 30 degrees, 24 degrees or 10 degrees central field test, depending on the pathology. One of the following perimeters should be used for the assessment: Goldmann Perimetry (Intensity III/4), Humphrey Field Analyzer or Octopus (Interzeag).

**2. Additional medical documentation (mandatory)**

Please specify which eye condition the athlete is affected by.

Eye condition	Additional medical documentation <u>required</u> (see below)
<input type="checkbox"/> Anterior disease	none
<input type="checkbox"/> Macular disease	<ul style="list-style-type: none"> <li>▪ Macular OCT</li> <li>▪ Multifocal and/or pattern ERG*</li> <li>▪ VEP*</li> <li>▪ Pattern appearance VEP*</li> </ul>
<input type="checkbox"/> Peripheral retina disease	<ul style="list-style-type: none"> <li>▪ Full field ERG*</li> <li>▪ Pattern ERG*</li> </ul>
<input type="checkbox"/> Optic Nerve disease	<ul style="list-style-type: none"> <li>▪ OCT</li> <li>▪ Pattern ERG*</li> <li>▪ Pattern VEP*</li> <li>▪ Pattern appearance VEP*</li> </ul>
<input type="checkbox"/> Cortical / Neurological disease	<ul style="list-style-type: none"> <li>▪ Pattern VEP*</li> <li>▪ Pattern ERG*</li> <li>▪ Pattern appearance VEP*</li> </ul>

Athlete: \_\_\_\_\_

The ocular signs must correspond to the diagnosis and degree of vision loss. If eye condition is obvious and visible and explains the loss of vision, no additional medical documentation is required. Otherwise the additional medical documentation indicated in the above table must be attached to this form. If the medical documentation is incomplete, the classifiers will not be able to allocate a sport class.

**\*Notes on electrophysiological assessments (VEPs and ERGs):**

Where there is discrepancy or a possible discrepancy between the degree of visual loss, and the visible evidence of ocular disease the use of visual electrophysiology is often helpful in demonstrating the degree of impairment.

Submitted data should include the report from the laboratory performing the tests, copies of the original data, the normative data range for that laboratory, and a statement specifying of the equipment used, and its calibration status. The tests should be performed as a minimum to the standards laid down by the International Society for Electrophysiology of Vision (ISCEV) (<http://www.iscev.org/standards/>).

A Full Field Electretinogram (ERG) tests the function of the whole retina in response to brief flashes of light, and can separate function from either the rod or cone mediated systems. It does not however give any indication of macular function.

- A Pattern ERG tests the central retinal function, driven by the macular cones but largely originating in the retinal ganglion cells.
- A Multifocal ERG tests the central area (approx. 50 degrees diameter) and produces a topographical representation of central retinal activity.

A Visual evoked cortical potential (VEP) records the signal from produced in the primary visual cortex, (V1), in response to either a pattern stimulus or pulse of light. An absent or abnormal VEP is not in itself evidence of specific optic nerve or visual cortex problems unless normal central retinal function has been demonstrated.

- A Pattern appearance VEP is specialised version of the VEP used to establish visual threshold which can be used to objectively demonstrate visual ability to the level of the primary visual cortex.

<input type="checkbox"/> I confirm that the above information is accurate.	
<input type="checkbox"/> I certify that there is no contra-indication for this athlete to compete at competitive level.	
Name: _____	
Medical Specialty: _____	
Registration Number: _____	
Address: _____	
City: _____	Country: _____
Phone: _____	E-mail: _____
Date: _____	Signature: _____