



**DECLARATION
Of PHYSIOLOGICAL CONDITIONS**
(please print all information and complete in English)



Athlete's Name: _____
Country: _____
Registration No. (If known) _____

Certain physiological conditions may prevent an athlete from performing strokes correctly in accordance with DSISO Rules. This form is to be used to document those conditions, for an assessment by the DSISO Medical and Technical Staff to allow for Exemptions to be authorised from the DSISO Rules. These Exemptions will be subject to review by DSISO Medical and Technical Director during competition.

The form is to be resubmitted not less than every two (2) years for review of the conditions.

DECLARATION The above named athlete has the following physiological conditions which impact on his/her ability to perform swimming and athletics strokes in accordance with the published rules:

(Please provide outline diagnosis of physical impairment/condition, together with an estimate of physical effect on swimming and strokes)

Continue on a separate page if necessary. Please attach details of medical diagnosis/physical conditions for the assessment of the DSISO Medical Officer

DIAGNOSIS: applicable Please attach medical Letter/Evidence
Down Syndrome 21 Mosaic Down Syndrome

AAI – Atlanto Axial Instability

Symptomatic AAI Asymptomatic AAI Clear

1. Did the athlete have appropriate physical health to participate on the tournament?

Yes No Restrictions _____

2. Does he/she take any medication? Yes No In case of Yes, which?

Substance(s): Generic name	Dose of administration	Route of Administration	Frequency of Administration
1.			
2.			
3.			

Intended Duration of Treatment <i>(please pick an appropriate box)</i>	Once Only <input type="checkbox"/> Emergency <input type="checkbox"/>
	Duration (week/month)

3. Does he/she have any medication allergy? Yes No In case of Yes, which?

4. Does he/she have any food allergy? Yes No In case of Yes, which?

5. Does he/she have any food intolerance? Yes No In case of Yes, which?

6. Health care: Allergies Asthma Skin Epilepsy Lung

7. Surgery _____

8. Any special care: _____

9. Vaccines: Tetanus __/__/__; Hepatitis __/__/__

Medical practitioner's and athlete's declaration

I certify that the above-mentioned treatment is medically appropriate and that the use of alternative medications may need registering on a TUE Form according the WADA Code.

DOCTOR /CONSULTANT contact information: MAILING ADDRESS

Name:		Doctor's Name Surgery Stamp Essential
Medical Speciality		
Address City, Post Code, Country		
Phone (inc Country Code)		
Fax		
Email		
Signed		
Signature of Swimmer		
Signature of Parent/Guardian (if under age 18)		
Name	Date	

CONFIDENTIAL

Information on the form is covered by the Data Protection Act 1998 (UK)¹

¹ This form has been modified in April 2009 following advice from the DSISO Medical Officer