disabled children ($p < 0.001$), prosthetics, orthotics - $38.74 \pm 3.27\%$ ($p < 0.001$).

$32.43 \pm 3.14\%$ of disabled children in need received sanatorium-resort treatment, $30.18 \pm 3.08\%$ are currently queuing for a voucher. For various reasons, this type of rehabilitation was abandoned by $24.32 \pm 2.88\%$, and $3.60 \pm 1.15\%$ of patients (all $p < 0.001$) contraindicated at the time of the ticket.

P314

LEADING DISABILITIES IN THE STATE OF HEALTH AS A SIGN OF REDUCING THE QUALITY OF LIFE OF CHILDREN WITH DISABILITIES IN THE CITY'S CHILDREN'S POLYCLINIC

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The nature and severity of leading disabilities in health status of children with disabilities have a decisive influence on quality of their lives according to their physical and psychosocial characteristics.

The analysis of structure and frequency of leading limitation of vital activity in state of health of 1611 disabled children in 2011–2018 is carried out in contingent of patients.

Seven major life limitations in the health status of children with disabilities were identified: 1) Reduced ability to self-care: to manage physiological functions; to maintain personal hygiene; to perform daily household activities; to eat; 2) Reduced ability to move independently: to walk; to overcome obstacles; to move; to maintain balance when moving; to maintain balance when resting or changing body position; to use transport; 3) Reduction of the ability to orientate: to adequately perceive the situation and assess the situation; to determine location in time and space; 4) Reduced ability to communicate: to understand and express thoughts through language; to establish contacts; to listen; to see; 5) Reduction in the ability to control one's behavior: to be aware of oneself; to understand, interpret and cope with the situation; 6) Reduction of the ability to learn: to perceive, memorize, assimilate and reproduce knowledge; to master skills and abilities; 7) Reduced ability to work.

The leading limitation of ability to self-care was established in 581st disabled children (I rank, $36.06 \pm 3.38\%$ of patients). On the II rank place - the leading restriction of the ability to self-movement - $32.59 \pm 3.30\%$. Much less frequently, the leading limitation of the ability to communicate is established - $13.22 \pm 2.39\%$ and the leading limitation of the ability to learn - patients $12.97 \pm 2.37\%$ (all $p < 0.001$). The two subsequent V and VI ranking places respectively occupied the leading limitations of the ability to orientate ($2.54 \pm 1.11\%$, $t = 2.288$) and the ability to control one's behavior ($1.99 \pm 0.98\%$, $t = 2.031$). The leading limitation of ability to work did not exceed $0.63 \pm 0.56\%$ ($t = 1.125$).

The frequency of leading self-service limitation is 46.99 ± 3.31 per 10,000 contingent of children and is 1.11 times higher than that of independent movement (42.46 ± 3.48), 2.73 times the ability to communicate (17.23 ± 2.66) and 2.78 times the ability to learn (16.90 ± 2.64). The leading restriction of the ability to orientate (3.32 ± 1.26) and the

ability to control one's behavior (2.59 ± 1.12) were set respectively 14.15 and 18.14 times less than the leading restriction of the ability to self-service.

P315

MEDICAL SUPPORT OF COMPLIANCE WITH THE STANDARDS OF PHYSICAL CULTURE AND SPORTS COMPLEXES BY A CONTINGENT OF PATIENTS OF THE CITY CHILDREN'S CLINIC AS A MARKER OF THE PHYSICAL DEVELOPMENT OF CHILDREN AND ADOLESCENTS OF THE SUBARCTIC TERRITORY

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Medical support of compliance with standards of physical culture and sports complexes is carried out on basis of established regulatory documents.

In SBAH RK 'SCC №3', patients aged 6–17 years who wish to take part in implementation of standards are subject to examination.

The provision of medical assistance in implementation of standards includes the organization of: primary medical and specialized medical care in order to issue admission to implementation of standards to individuals who wish to take part in implementation of standards and the provision of primary medical and ambulance services, including emergency specialized medical assistance in implementation of standards to all participants.

Admission to implementation of the standards of students of educational institutions of preschool and general secondary education is carried out on basis of assigning the child to the main medical group for physical training by pediatricians of medical organizations.

If a minor citizen who wants to be tested, has a disability or a preparatory medical group for physical training, he is sent to the doctor in sports medicine (specialty 'medical and sports medicine').

The purpose of examining a doctor in sports medicine is to evaluate the response of the cardiovascular system to an increase in load and to determine the possible passing of testing in the relevant group. Conclusion with the decision on admission in this case is made by a doctor in sports medicine.

In the clinic in the 2016–2018 years. 807 children applied for examination, of which 787 were allowed to pass sports standards ($97.52 \pm 0.30\%$), corresponding to the years 2016 - 23 ($95.83 \pm 4.08\%$), 2017 - 491 ($96.84 \pm 0.78\%$), 2018 - 273 ($98.91 \pm 0.62\%$). In the structure of admitted children 13–15 years old (31.00%) and 11–12 years old (25.41%) prevailed over other age groups 9–10 years old (19.95%), 16–17 years old (12.58%) and 6–8 years (11.06%).

If in 2016 only 24 people applied for certification, then in the next 2017 their number increased to 507, that is, 21.13 times. In this case, all patients were divided into three medical groups: the main - 443, preparatory - 52 (of which 4 children were not admitted) and special - 12.

Of the 807 children and adolescents examined over 3 years, the main medical group for physical training was established $87.73 \pm 1.15\%$ of those examined, preparatory - 10.78