CAROLINAS ASSOCIATION OF CHINESE MARTIAL ARTS
2024 LEI TAI (FULL CONTACT FIGHTING)
PRE-PARTICIPATION HEALTH QUESTIONNAIRE

Part A: Health History Questionnaire – to be completed by competitor and reviewed with licensed MD or equivalent.

Part B: Physical Evaluation – to be completed by licensed provider with MD or equivalent.

*****These forms must be submitted to sifufacente@gmail.com by March 9, 2024*****

Bring both completed forms to Lei Tai weigh-in/registration on March 16, 2024 at the tournament site.

Part A: Health History Questionnaire (completed by competitor)

Document MUST be completed on or after February 1, 2024

Today's Date: _______________

Competitor Name: __________________________________ Date of Birth: _______________

Age: __________ Sex assigned at birth (circle one): M F

Country: _________________________

Emergency contact during competition: ____

Relationship: _________________________

Phone number of emergency contact during competition: _______________________________

Please answer the following questions about your medical history. Explain all "yes" responses below.

Have you ever or do you currently have:

1. **Restriction from sports for a health-related problem? Y / N**
2. **A chronic or ongoing illness (such as diabetes or asthma)? Y / N**
3. **Surgeries or hospitalization? Y / N**
4. **Any medications that you take on a regular basis? Y / N**
5. **Any allergies to medications? Y / N**
6. **Seizures or head injuries? Y / N**
7. **Restrictions from sports for heart problems or a heart murmur? Y / N**

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Part B: Physical Evaluation (completed by licensed MD or equivalent*)

Document MUST be completed on or after September 14, 2023

Competitor's Name _______________________________ Birth Date ___________________

Height _________________ Weight ______________ Pulse ___________ Blood Pressure _____/_____

Physical Examination

	Normal	Abnormal Findings
Head, Ears, Eyes, Nose,		
Throat (HEENT)		
Lungs		
Heart		
Abdomen		
Skin		
Musculoskeletal		
Neurologic		

Pertinent current medical conditions:

Medications:

*** Licensed MD or equivalent:**

This form must be completed by a licensed medical doctor (MD) or equivalent -- a nurse practitioner or a physician's assistant. License must be current.

We will not accept an evaluation form completed by acupuncturists, Oriental Medical Doctors (OMD), Traditional Chinese Medicine (TCM) doctors, dentists, oral surgeons, chiropractors, podiatrists, registered nurses, or other specialties that are not suited to evaluate fitness to compete in this event.

Communicable disease: Positive / Negative

Pregnancy test (women only) result: Positive / Negative Date of test: _______________

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Notes:

1. **Competitors with known communicable disease (Hepatitis B, Hepatitis C, HIV) will not be permitted to compete in the Lei Tai full exhibition matches.**
2. **No pregnant competitors will be permitted to compete in the Lei Tai full exhibition matches.**

Medical Clearance

I certify that on this date I have examined ____________________________ (name of competitor) and, on the basis of the exam and the medical history furnished to me, I have found no reason that would make it medically inadvisable for him/her to compete in the Lei Tai full contact fighting event during on October 14th, 2023.

____

Medical examiner's name (print)

____

Medical examiner's signature

____

Date

____

Office name, address and phone number

Circle: Medical Doctor (MD) Nurse practitioner Physician's assistant

License Number: _______________________