

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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Explain all “yes” answers to questions 1 - 7 here (attach extra pages, if required):

List all current medications here:

I, _____ (print name) attest that I have completed the requested health history questionnaire thoroughly and truthfully to the best of my knowledge.

Furthermore, I understand and agree that participation in the 2023 Lei Tai full contact fighting event will require me to provide this questionnaire, and the results of a physical examination to the tournament staff. I also understand and agree that this information will be provided to onsite emergency medical providers. I release CACMA their officials, agents, representatives, employees, and all other related members from liability due to any disclosure of my medical condition.

Competitor's signature Date

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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: _____