美國國術總會
United States Kuo Shu Federation
President:
Grandmaster Huang, Chien-Liang
會長:
黃乾量

2025 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.

Bring both completed forms to Lei Tai weigh-in on July 25, 2025 at the tournament site. Also bring the lab report demonstrating blood tests performed May 30, 2025 or later.

Questions regarding these forms or the Lei Tai competition may be sent to leitai@usksf.org

Part A: Health History Questionnaire (completed by competitor)
Document MUST be completed on or after May 30, 2025

Today's Date: _____

Competitor Name: _____ **Sex assigned at birth:** **M** **F** **Age:** _____

Date of Birth: _____ **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**

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

List all current medications here:

PO Box 927, Reisterstown, Maryland 21136-0927 USA
Tel: 443-394-9200 Fax: 443-394-9202 Website: www.usksf.org Email: info@usksf.org
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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 2025 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 release Huang Chien-Liang, The World Kuo Shu Federation Inc., the United States Kuo Shu Federation, Inc., 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 May 30, 2025

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, a registered nurse, 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, or other specialties that are not suited to evaluate fitness to compete in this event.

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HIV testing result:	**Positive /**	**Negative**	**Date of test: _____**
Hepatitis B testing result:	**Positive /**	**Negative**	**Date of test: _____**
Hepatitis C testing result:	**Positive /**	**Negative**	**Date of test: _____**
Pregnancy test (women only) result:	**Positive /**	**Negative**	**Date of test: _____**

Notes:

1. **All test results must be completed on or after May 30, 2025.**
2. **Prior immunization for Hepatitis B and/or Hepatitis C will not be accepted as a substitute for current Hepatitis B and Hepatitis C test results.**
3. **No pregnant competitors will be permitted to compete in the Lei Tai full contact event.**

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 the period of July 25 to 27 July 2025.

_____
Medical examiner's name (print)

_____
Medical examiner's signature

_____
Date

_____
Office name, address and phone number

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

License Number: _____

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