

## Circle K International MEDICAL INFORMATION FORM

Please type or print. A completed medical information form is required for all participants attending this Circle K event and is to be turned upon registration. Please keep one copy of this form with you at all times during the convention.

Registrant's Name \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_

(Street) (City) (State/Province) (Zip Code)

Country \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Circle K Club \_\_\_\_\_ District \_\_\_\_\_

Person to be contacted in case of emergency \_\_\_\_\_

Relationship \_\_\_\_\_ Home phone (\_\_\_\_) \_\_\_\_\_ Work phone (\_\_\_\_) \_\_\_\_\_

Alternate Contact \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

(Name) (Relationship) (Phone)

Name of Doctor \_\_\_\_\_ Phone number(\_\_\_\_) \_\_\_\_\_

Doctor's Address \_\_\_\_\_

Name of Health Insurance Co. \_\_\_\_\_ Policy Number \_\_\_\_\_

List any other pertinent information as shown on insurance card \_\_\_\_\_

List any medication you will be taking during the convention \_\_\_\_\_

### Please answer yes or no to the following items:

1. Have you ever been treated for: (If currently being treated, please indicate)

A. Nervousness \_\_\_\_\_ H. High Blood Pressure \_\_\_\_\_

B. Any Mental Disorder \_\_\_\_\_ I. Severe or Frequent Headaches \_\_\_\_\_

C. Convulsions or Epilepsy \_\_\_\_\_ J. Asthma \_\_\_\_\_

D. Fainting Spells \_\_\_\_\_ K. Ulcers \_\_\_\_\_

E. Heart Condition \_\_\_\_\_ L. Diabetes \_\_\_\_\_

F. Rheumatic Fever \_\_\_\_\_ M. Allergic Reaction to Medication \_\_\_\_\_

G. Cancer or Tumor \_\_\_\_\_ N. Any Other Allergies or Illnesses \_\_\_\_\_

2. Do you have any other physical limitations? \_\_\_\_\_

Give details of yes answers to any of the questions above. Give dates of treatment, and names and addresses of attending physicians, hospitals and clinics. (Use reverse side if necessary.)

### PLEASE READ CAREFULLY

I hereby certify that the information given above is correct. In case of medical emergency, I understand that every effort will be made to contact the person designated above. In the event that the aforementioned contact person cannot be reached, or time does not permit, I hereby give permission to a licensed physician to provide proper treatment, including hospitalization, immunization or injection, anesthesia or surgery.

Signature \_\_\_\_\_ Date \_\_\_\_\_