



### Circle K International MEDICAL INFORMATION FORM

Please type or print. A completed medical information form is required for all participants attending the Circle K International Convention and is to be turned in at the Convention Registration Desk. 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/Postal 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(s) designated above. In the event that the aforementioned contact person(s) 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 \_\_\_\_\_