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______________________