Pennsylvania District of Circle K
District Convention 2020
Medical Information Form

A medical information form is required for participants attending the 2020 Pennsylvania District Convention. **Please print this form and bring to the convention.**

Registrant's Name______________________________Height__________Weight__________Sex ____________

Address ____
(Street) (City) (State/Province) (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 _______________________________________

List any allergies you have ____

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 ______________________ Name (Print) ______________________ Date ____________________