

Circle K International
Medical Questionnaire and Emergency Medical Treatment Authorization Form

Please type or print. This form is required of all participants attending the Circle K Events. This form must be turned in at the convention registration desk.

Registrant's Name _____ Height _____ Sex _____
Address _____
(street) (city) (state) (zip code)

Person to be contacted in case of emergency _____

Relationship _____ Home Phone _____ Work Phone _____

Alternate Contact _____
(name) (relationship) (phone)

Name of Doctor _____ Phone _____

Doctor's Address _____
(street) (city) (state) (zip code)

Name of Health Insurance Co. _____ Policy # _____

List any pertinent information shown on insurance card _____

PLEASE ANSWER YES OR NO:

Will you be taking medication of any type during convention? Yes _____ No _____

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

Nervousness	_____	High Blood Pressure	_____
Any mental disorder	_____	Severe or Frequent Headaches	_____
Convulsions or epilepsy	_____	Asthma	_____
Fainting spells	_____	Ulcers	_____
Heart Conditions	_____	Diabetes	_____
Rheumatic Fever	_____	Allergic Reaction to Medication	_____
Cancer or Tumor	_____	Any other allergies or illness	_____

Do you have any other physical limitations? _____

Give any details of yes answers to any of the questions above. Give dates of treatment and names and addresses of attending physicians, hospital, 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 person cannot be reached, or time does not permit, I hereby give permission to a licensed physician to provide proper treatment for, including hospitalization, immunization or injection, anesthesia or surgery.

Signature _____ Date _____