



Pennsylvania District of Circle K International InterPACK 2023 Medical Information Form

A medical information form is required for participants attending InterPACK. **Please print this form and bring it filled out to the InterPACK.**

Registrant's Name _____

Height _____ Weight _____ Sex _____

Address _____
(Street) (City) (State) (ZIP Code)

Country _____ Date of Birth (mm/dd/yy) ____/____/____ Age ____

Circle K Club _____ District _____

Emergency Contact _____

Relationship _____ Primary phone (_____)

Alternate Contact _____

Relationship _____ Primary phone (_____)

Name of Doctor _____ Primary phone (_____)

Doctor's
Address _____
(Street) (City) (State) (ZIP Code)

Health Insurance Company _____ Policy Number _____

List any other pertinent information as shown on insurance card

continued on next page

List any medication you will be taking during the convention

Please answer yes or no to the following items (If currently being treated, please indicate):

1. Have you ever been treated for:

- | | | | |
|----------------------------|-------|-------------------------------------|-------|
| 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.

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.

Name (Print) _____

Signature _____

Date _____