Pennsylvania District of Circle K International
District Convention 2026 Medical Information Form

A medical information form is required for participants attending DCON. **Please print this form and bring it filled out to the DCON** or **email it to Administrator@pacirclek.org**.

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 _____