



# MEDICAL INFORMATION FORM

## PNW CKI 2024-2025

A medical information form is not required for participants attending PNW CKI DCON; however, if you have a chronic health condition or other medical needs that should be noted to the CKI staff, please complete this medical information form, and turn it in at the registration desk. Please keep one copy of this form with you at all times during the convention. Please print.

Registrant's Name \_\_\_\_\_ Cell Phone (\_\_\_\_) \_\_\_\_\_

Address \_\_\_\_\_  
(Street) (City) (State/Province) (Postal Code)

Country \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_ Gender \_\_\_\_\_

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(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 \_\_\_\_\_ Date \_\_\_\_\_