

# 2009 medical release form

Please type or print. A completed medical information form is required for all participants attending the Circle K International convention and is to be turned in at the convention registration desk. Please keep one copy of this form with you at all times during the convention.

Registrant's name \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Sex \_\_\_\_\_

Address \_\_\_\_\_  
(Street)

\_\_\_\_\_  
(City) (State/Province) (ZIP/postal code)

Country \_\_\_\_\_ Date of birth \_\_\_\_/\_\_\_\_/\_\_\_\_ Age \_\_\_\_\_

Circle K club \_\_\_\_\_ District \_\_\_\_\_

Person to be contacted in case of emergency:

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Home phone (\_\_\_\_) \_\_\_\_\_ Work phone (\_\_\_\_) \_\_\_\_\_

Alternate contact \_\_\_\_\_ Relationship \_\_\_\_\_

Home phone (\_\_\_\_) \_\_\_\_\_ Work phone (\_\_\_\_) \_\_\_\_\_

Name of doctor \_\_\_\_\_ Phone number (\_\_\_\_) \_\_\_\_\_

Doctor's address \_\_\_\_\_

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 \_\_\_\_\_

Parent Signature (if under 18) \_\_\_\_\_ Date \_\_\_\_\_