PNW 2023 DCON
MEDICAL INFORMATION FORM

A medical information form is not required for participants attending 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_____