Medical Information Form

Please type or print. A completed medical information form is required for all participants attending Georgia District Circle K events 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: _____

City: _____ State: _____ ZIP: _____

Country: _____ Date of Birth: ____/____/_____ Age: _____

Person to be contacted in case of emergency:

Name: _____

Relationship: _____

Home Phone: (____) _____

Work Phone: (____) _____

Name of Doctor: _____

Alternate Contact:

Name: _____

Relationship: _____

Home Phone: (____) _____

Work Phone: (____) _____

Phone Number: (____) _____

Address/City/State/ZIP: _____

Name of Health Insurance Co.: _____ Policy #: _____

List any other pertinent information shown on insurance card: _____

List any medication you will be taking during the convention: _____

_____

Please Circle Yes or No to the following items:

1. Have you ever been treated for: (If currently being treated, please indicate)

Y	N	Nervousness?	Y	N	High Blood Pressure?
Y	N	Any Mental Disorder?	Y	N	Severe or Frequent Headaches?
Y	N	Convulsions or Epilepsy?	Y	N	Asthma?
Y	N	Fainting Spells?	Y	N	Ulcers?
Y	N	Heart Condition?	Y	N	Diabetics?
Y	N	Rheumatic Fever?	Y	N	Allergic Reaction to Medication?
Y	N	Cancer or Tumor?	Y	N	Any other allergies or illnesses?

2. Do you have any other physical limitations? _____
3. Do you have a disability requiring special arrangements? Yes _____ No _____ If yes, what special arrangements do you require? _____
4. Please give details to "yes" answers to any of the questions above. Give dates of treatment, and names and addresses of attending physicians, hospitals and clinics. (Use additional sheets if necessary.) _____

_____

Please Read Carefully: I hereby certify that the information given above is correct. In case of medical emergency, I understand every effort will be made to contact the person designated above. In the event that person 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. (If you are under the age of 18, your parent or legal guardian must sign this form.)

Signature: _____ Date: _____