



NEW JERSEY CKI MEDICAL INFORMATION FORM

Please type or print. A completed medical information form is required for all participants attending the NJ CKI INSIGHT and is to be turned in at registration.

Name _____ Height _____ Weight _____ Sex _____

Address _____
(Street) (City) (State/Province) (Postal Code)

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

Circle K Club _____

Person to be contacted in case of emergency _____

Relationship _____ Cell 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 all medications you will be taking during the Academy _____

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 _____