RMD CKI DCON 2022 Medical Release Form

Please bring this completed medical release form to check-in on Friday, February 25th. Participants will be unable to participate in the convention's activities unless the form is completed in its entirety. Please contact Ellie Martinez (governorrmd@gmail.com) if you have any questions or concerns.

Registrant's Name: _____ Height: _____ Weight: _____

Email: _____ Phone Number:_____ Text Okay? (circle one) Y N

Address:_____
(street) (city) (State/Province) (zip code)

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

Circle K Club: _____ District: _____

Person to be contacted in case of emergency: _____

Relationship: _____ Cell Phone: _____ Other Phone: _____

Alternate Contact:_____
(name) (relationship) (phone)

Name of Doctor: _____ Phone Number: _____

Doctor's Address: _____

Health Insurance Company: _____ Policy Number: _____

Other pertinent information shown on insurance card: _____

List any medications you will be taking during the event: _____

Please answer yes (Y) or no (N) to the following questions:

I. Have you ever been treated for… (if currently being treated, please indicate)

Nervousness	_____	High Blood Pressure	_____
Any Mental Disorder	_____	Severe/Frequent Headaches	_____
Convulsions or Epilepsy	_____	Asthma	_____
Fainting Spells	_____	Ulcers	_____
Heart Condition	_____	Diabetes	_____
Rheumatic Fever	_____	Allergic Reaction	_____
Cancer or Tumor	_____	Other	_____

II. Do you have any physical/mental limitations? _____

III. Please provide details of yes answers to any of the questions above. Give dates of treatment, 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 the case of a 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: _____