Please join us in celebrating…

Indiana University of Pennsylvania's

Gobble Gobble!

Get into the "Spirit" of Giving

When: Friday and Saturday October 28th - 29th

Where: Laurel Lodge

2319 Sugar Run Rd

Duncansville, PA 16635

Times: Arrival on Friday at 7:00 pm

Event ends on Saturday at 1 pm

Cost: $8.00 / $10.00 for late registration

Come and join in fun service as well as games, food, and friends!
Hope to see you there!

R.S.V.P. to Stephanie Phillips by October 12th
717-385-1331
s.a.phillips2@iup.edu

GOBBLE, GOBBLE

REGISTRATION FORM

CIRCLE K CLUB NAME: ____

CLUB PRESIDENT'S NAME: ____

CLUB PRESIDENT'S PHONE #: ____

CLUB PRESIDENT'S EMAIL: ____

TOTAL NUMBER OF MEMBERS ATTENDING: ___________

AMOUNT ENCLOSED: $___________

	NAME	FOOD/OTHER ALLERGIES
1		
2		
3		
4		
5		
6		
7		
8		
9		
10		
11		
12		

CIRCLE K INTERNATIONAL MEDICAL INFORMATION FORM

A COMPLETED MEDICAL INFORMATION FORM IS REQUIRED FOR ALL PARTICIPANTS ATTENDING GOBBLE, GOBBLE 2011 AND TO BE SENT IN WITH THE REGISTRATION FORM.

NAME____ **HEIGHT**________ **WEIGHT**_________ **SEX**________

ADDRESS____

DATE OF BIRTH_____/_____/______ **AGE**__________ **CIRCLE K CLUB**___________________________________

PERSON TO BE CONTACTED IN CASE OF EMERGENCY____

RELATIONSHIP________________ **HOME PHONE (**______**)**____________ **WORK PHONE (**_____**)**____________

ALTERNATE CONTACT____(_______)______________
(NAME) (RELATIONSHIP) (PHONE)

NAME OF DOCTOR ____ **PHONE (**______**)**__________________

DOCTOR'S ADDRESS____

NAME OF HEALTH INSURANCE CO.______________________________ **POLICY #** ________________________

LIST ANY OTHER PERTINENT INFORMATION AS SHOWN ON INSURANCE CARD
____

ANY MEDICATION:____

PLEASE ANSWER YES OR NO TO THE FOLLOWING:

1. HAVE YOU EVERY 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? ____________
   ____

3. 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 BACK 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 PERMIT A LICENSED PHYSICIAN TO PROVIDE PROPER TREATMENT, INCLUDING HOSPITALIZATION, IMMUNIZATION OR INJECTION, ANESTHESIA, OR SURGERY.

SIGNATURE____ DATE_________________