

The Minnesota-Dakotas District Circle K International

2008 District Convention ♠ February 29 – March 2, 2008 ♠ St. Cloud, MN

1. READ THESE INSTRUCTIONS before completing this form! PLEASE PRINT LEGIBLY!
2. Use one registration form per attendee. Be sure to carefully read these instructions and complete the medical form on the other side of this registration form. All conference attendees are required to complete medical forms. You may want to make a copy of this form for your files.
3. **The registration must be postmarked by February 1st, 2008.** A completed registration packet will include this form, the medical form, and full payment of **registration rate listed below per room request.**
4. Registration for includes all meals on Saturday, including the Extravaganza, brunch on Sunday, workshop materials, lodging, and other conference activities and materials.
5. *Cancellation requests must be made in writing to the District Administrator and will be handled on a case by case basis.* Cancellations requests and refunds will not be decided upon until after the District Convention.
6. Circle K Members do NOT need to make hotel registrations. Circle K members will be responsible for damage to the hotel as a result of their stay.
7. Method of payment: We will accept personal/school checks and money orders (please do not send cash through the mail).
8. **If your registration fee is not postmarked by February 1st, 2008, you will be subject to a \$5 late fee.**
9. Make checks payable to the Minnesota-Dakotas District of Circle K. Mail payment with this completed form to

2007 DCON
c/o Jodi Piekarski
20236 Little Crystal Springs Road
Grand Rapids, MN 55744.

10. If you have any questions, please call District Governor Matt Schuweiler at (651) 307-8810 or District Administrator **Ann Backes Dodge** at 218-259-1594.

Check all boxes that apply to you:

	Male	Circle K'er	Kiwanian	Kiwanis Advisor
		Circle K	K-Family	Faculty
	Female	Alum		Advisor
# of People in Room	4 people	3 people	2 people	1 person
Circle Choice				
Registration Rate	\$160	\$180	\$211 (2 – double beds) \$203 (1 – Queen bed)	\$301 (1 – Queen bed)

Last Name: _____ First Name: _____

Nickname: _____ E-Mail Address: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: (____) _____ Office Held (if applicable): _____

Circle K/Kiwanis Club: _____

HOTEL INFORMATION: Best Western Kelly Inn, St. Cloud, MN.

- q Enclosed is my check made payable to Minn-Dak CKI for \$_____ (If check is for more than one registration attach a list with check stating registrants covered by check/money order.
- q Enclosed is my Code of Conduct Form.
- q Enclosed is my Medical Form.

Do you have any special meal requirements? Yes _____ No _____ Please Explain: _____

Medical Information Form

Please type or print. A completed medical information form is required for all participants attending Minn-Dak 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:

Alternate Contact:

Name: _____

Name: _____

Relationship: _____

Relationship: _____

Home Phone: (____) _____

Home Phone: (____) _____

Work Phone: (____) _____

Work Phone: (____) _____

Name of Doctor: _____

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

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: _____