NTS 2025 Honored Guest Registration Form
First Methodist Church Clewiston, FL
Event: 2/7/25 6-9pm @ 331 W Osceola Ave, Clewiston 33440
Fax when completed to: 561-996-5598
Or Email completed form: NTSClewiston@yahoo.com
Note: All NTS participants must complete/send a Media Release Form.

Honored Guest Information

First Name: _____ Last Name: _____

Name as you would like it to appear on nametag:

_____

DOB: _____ Gender: Female: ____ Male: ____

Address:

_____

City: _____ State: _____ Zip Code: _____

Email: _____ Phone: _____

Fun Fact About You:_____

Emergency Contact during event (will be listed on guest's nametag):

_____

Emergency Contact Phone (will be listed on guest's nametag):

_____

Will Need Medication Administered During Event*: Yes: ____ No: ____

**** Please note that the First Methodist Church Clewiston, their staff, and volunteers are not responsible for administering medication to guests during the Night to Shine event. If medication is required during the event, a parent or caretaker MUST be available to administer the medication.***

Will guest be dropped off and picked up by parent/caretaker? Yes: ____ No: ____

Will guest be taking public transportation to and from event? Yes: ____ No: ____

Will guest be attending as a part of a group that will provide transportation?
Yes: ____ No: ____

We would love to make your Night to Shine experience the best it can possibly be. If you are comfortable sharing, please answer any of the following optional items that apply in order to help us offer the best support we can.

Health Concerns: _____

Mobility Needs:_____

Communication Needs:_____

Sensory Issues/Concerns (strobe lights, camera flashes, loud noises, etc.):

_____

Allergies:_____
(Please list any that apply: foods, animals, latex, makeup, plants or pollen, etc.)

Food Needs (food cut-up or pureed, gluten free, dairy free, nut free, etc.):

_____

Additional Notes/Concerns You Would Like Us to Be Aware Of

_____

_____

_____

_____

Caretaker Information

Caretaker Name(s):_____

Caretaker Phone: _____

Caretaker will be… Dropping Guest Off: ____ Enjoying Respite Room: ____

Caretaker relationship to guest: _____

If enjoying Respite Room*, please list Caretakers:
Name 1: _____

Name 2:_____

** The Respite Room is a private area where caretakers of guests can spend the evening enjoying food, entertainment, and rest while remaining onsite during the event.*

Care Provider Agency Information – If Applicable

Care Provider Agency:

_____
(If attending as a part of a group, please include agency or company name)

Care Provider Agency Phone:_____

Agency Chaperone (if applicable):_____

Agency Chaperone Cell Phone:_____
(Note: Chaperone is not required to stay with guest(s) unless required by Care Provider Agency. If Chaperone remains with guest, a current Background Check will be required.)

Additional Notes or Concerns:

_____

_____

_____

_____

NTS Notes: _____