Night to Shine
TIM TEBOW FOUNDATION

Night to Shine

St. Edward Guest Registration Form

Guest Information

First Name: ______________________ Last Name:_________________________

Name as you would like it to appear on name tag:

____

DOB: ________________________ Gender: Female Male

Address:

____

City: _______________________________ State: _________

Zip Code:_________________

Email: ____

Phone:_____________________

IMPORTANT: Fun Fact About You to Be Read During Your Red Carpet Entrance:

____

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

____

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

____

Guest Information continued

Will Need Medication Administered During Event: Yes No

**** Please note that St. Edward parish, 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.***

Night to Shine honored guests will be paired with a volunteer buddy for the entire evening. If the guest prefers, he or she may bring his or her own caretaker to partake in the evening events in lieu of being assigned a volunteer buddy. Please let us know your preference:
Volunteer Buddy **Accompanied by own caretaker**

Please let us know how the registered guest will be transported to and from the event:

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.)

Information continued

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

____

____

Caretaker Information

Caretaker Name(s):____

Caretaker Phone: ____

Caretaker will be:
Staying with guest the entire evening in lieu of a volunteer buddy
Dropping Guest Off
Staying onsite and enjoying the 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 not partaking in the evening can relax, enjoy food, companionship, 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:____

Additional Notes or Concerns:

____

____

____

____

Please Remit completed form to: stedsnts@gmail.com