

# 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: \_\_\_\_\_

Fun Fact About You: \_\_\_\_\_

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

\_\_\_\_\_

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

\_\_\_\_\_

Will Need Medication Administered During Event: Yes: \_\_\_\_ No: \_\_\_\_

\* Please note that the church, 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 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:

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

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Allergies:

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

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

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

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Parent/Guardian Information

Parent/Guardian Name(s):

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Phone:

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Dropping Guest Off: \_\_\_\_ Enjoying Respite Room: \_\_\_\_

If enjoying Respite Room, please list Names:

Name 1:

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Name 2:

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\* The Respite Room is a private area where parents/guardians 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:

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

Care Provider Agency Phone:

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Agency Chaperone (if applicable):

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Agency Chaperone Cell Phone:

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Additional Notes or Concerns:

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Remit form to: Catalyst Church Altoona, Attention: April Blackie  
2500 4th Avenue, Altoona, PA 16602 or email to: [april@catalystchurchaltoona.org](mailto:april@catalystchurchaltoona.org)