Brotherhood Weekend and Congress 2010

Registration Form

MARCH 12-14 TH, 2010

Camp Round Meadow, Catoctin Mountain Park (near Thurmont, Maryland)

Name: ____

Address: ____

City, State Zip: ____

Phone: (____)______-_____________

Chapter: ____

Years in DeMolay: ________

Highest Office Held:__________________________________

Attended Congress before: **Yes/ No**
Representative DeMolay: **Yes / No**
LCC Courses: **Yes / No** , if so how many?:
T-shirtSize:**S M L XL**
(Please circle)

Please send completed Registration form and registration fee of:
$40.00 Active Maryland DeMolays
$60.00 Advisors
Make checks out to MSADC **with the note UDMC 2010**, to:

MSADC
P.O. Box 724
Reisterstown, MD 21136

Please complete release form on the back of this registration. Registration forms must be received by March 6th, 2007. Late applications will not be accepted.

Please fill out medical information ________________________________ ON BACK!

MEDICAL HISTORY AND RELEASE FORM

NAME OF PARTICIPANT: ____

Participants INDEMNIFICATION (REQUIRED OF ALL PARTICIPANTS)
I hereby promise to conduct myself in a responsible manner and abide by the DeMolay rules and regulations remembering that the future welfare of the Order of DeMolay is in my hands and to follow all of the rules and regulations for this DeMolay event. If I do not abide by this promise, I wil1 be subject to being returned home immediately at my own expense. In consideration of the DeMolay staff, I shall indemnify and hold DeMolay International, all affiliated organizations, and the DeMolay staff harmless from and against any and all penalties, losses, costs, damages, suits, judgments, claims, demands, expenses, and liabilities of any kind or nature whatsoever, arising directly or indirectly out of or In connection with my attendance at this DeMolay event.

PARTICIPANT'S SIGNATURE: ____ DATE: __________________

MEDICAL HISTORY

The DeMolay staff should be aware that this participant has experienced health problems with (please list all medical problems and medications being taken):

____
____
____
____
____

Insurance Information:

Name of Medical Insurance Company: ____
Medical Insurance Policy Number: ____
Name of Family Physician:________________________________ Phone: (_____)_____-_________
Physician Address/City/State: ____
In case of emergency, contact (name): ______________________ Phone: (_____)_____-________
Contact Address/City/State: ____

PARENTAL PERMISSION & MEDICAL RELEASE (for all under 18 years of age)
As the parent of, Legal Guardian of the participant named above. I hereby give my permission for the DeMolay Staff to enter the above named participant into a hospital of their choosing. They may also obtain medical attention or treatment by a physician, if in their opinion, the above named participant needs medical attention or treatment. I also agree, upon notification from the DeMolay Staff, to pick up the above named participant, if in the opinion of the DeMolay Staff, it is necessary that he/she be removed from the site of this DeMolay event. In addition, I agree on behalf of the above named participant, that his/her room may be entered if it is deemed necessary by the DeMolay Staff. In consideration of the DeMolay staff, I shall indemnify and hold DeMolay International, all affiliated organizations, and the DeM olay staff harmless from and against any and all penalties, losses, costs, damages, suits, judgments, claims, demands, expenses, and liabilities of any kind or nature whatsoever, arising directly or indirectly out of or In connection with above named participant's attendance at this DeMolay event.

PARENT/LEGAL GUARDIAN SIGNATURE: ____

Date:______________________