

**Conclave Registration Form
Maryland DeMolay Conclave
July 30 – August 1, 2010**

Name _____ Home Phone _____

Address _____

Chapter _____ Shirt Size _____

If under 21, age _____ (for rooming purposes only)

Affiliation (Check all that apply)

_____ Member _____ Sweetheart _____ Rainbow _____ Advisor
_____ Parent's Club _____ Job's Daughter _____ Chaperone (must be 21 years of age)

Email address _____

This section for DeMolays, Sweethearts, Rainbows and Job's Daughters

Advisor's Signature _____

Responsible Advisor/Chaperone _____
(Please Print)

Desired Roommate 1. _____

2. _____

Permission form (back) MUST be completed by everyone

Registration Fees and Deadlines

- Maryland DeMolay Only Pre-Registration - **\$55.00 (Prior to June 20th)**
- Advisor/ Guest Registration (3 day Conclave **\$135.00 (due by June 30th)**)
- All registrations received after June 30th **\$155.00**
- Saturday Lunch Only - **\$12.00 (due July 15th)**
- Sunday Banquet Only - **\$35.00 (due July 15th)**

NO REGISTRATIONS ACCEPTED AFTER JULY 15^h

Make Checks Payable to: MSADC Conclave 2010
PO Box 724
Reisterstown, MD 21136

Info Call Lee Reich 410-788-0364 or Richard Naegele- 410-665-5947

-----Office Use Only-----

Cash _____ Check _____ Date received _____ Initials _____

Permission Sheet

_____, is a member of _____ Chapter (Bethel, Assembly) Order of DeMolay, has my/our permission to travel to the Conclave to be held at **Salisbury State University** in Salisbury, Maryland on the Friday, July 30 (1:00pm) to Sunday, August 1, 2010 (4:00pm). I/We understand that he (she) will be traveling by private vehicle. I/We also understand that the accompanying advisor/ chaperone will make every effort to supervise and protect my/ our son (daughter), however, they shall not be responsible for accidents while in the advisor's/ chaperone's charge.

The advisor has the authority to have my/ our son (daughter) treated at an accredited medical facility in case of an emergency. I/We authorize treatment and request that the medical charges be placed against my/ our medical insurance, since DeMolay only carries liability insurance.

Name of Insurance Company (required) _____

Policy Number (required) _____

My son/ daughter has the following allergies or medical conditions:

My son/ daughter takes the following medication:

Signed (**required**) _____

Parent or Guardian

Parent or Guardian

Emergency Number (**required**) _____

Name _____ Relationship _____