NIGHT to Shine
SPONSORED BY THE TIM TEBOW FOUNDATION™

Return to **Norwalk 1st United Methodist Church**
Attn: DeAnn McKillips
60 W. Main Street
Norwalk, OH 44857
email: night2shine44857@gmail.com
Due by January 15, 2024

Guest First Name: _____ **Last:** _____

Name as you would like it to appear on nametag: _____

DOB: _____ Gender: Female: ____ Male: ____ Non-binary:____

Address:_____

City: _____ State: _____ Zip Code: _____

Email: _____ Phone: _____

Fun Fact About You: _____

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

Name: _____ Phone: _____

Will Need Medication Administered During Event: Yes: ____ No: ____
If Medication Administration is required, person who will complete task:_____

* *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.*

We would *LOVE* to make your Night to Shine experience the best it can possibly be. Please answer any of the following items that apply to help us offer the best support we can:

Health Concerns: _____

Mobility Needs: _____

Communication Needs: _____

Support or Supervision Needs:_____

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

_____

Allergies (Please list any that apply i.e., foods, animals, latex, make-up, plants, etc.):

_____

Food Needs (Check all that apply, do not leave blank)

- ☐ Pureed diet
- ☐ Soft-solid diet
- ☐ Regular diet
- ☐ Thin liquids
- ☐ Mildly thick liquids
- ☐ Moderately thick liquids
- ☐ Dairy free
- ☐ Gluten free
- ☐ Nut-free
- ☐ Food pre-chopped

If there are any other modifications or accommodations needed for dinner, please describe in below:

_____

_____

Caretaker Name: _____Phone: _____
Relationship to Guest: _____ Dropping Guest Off? _____

Caretaker Name: _____Phone: _____
Relationship to Guest: _____ Dropping Guest Off? _____

If Caretaker(s) will be staying for the event and enjoying the Respite Room, please list names below:

Name 1: _____

Name 2: _____

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 Name (if applicable):_____

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.)

Buddy Requested:_____
(Please note, we cannot ensure that the Guest will be placed with requested Buddy)

Additional notes, concerns or information that will ensure a great night for the guest:

_____

_____