

Conclave Registration Form
Maryland DeMolay Conclave
July 12-14, 2019

Name: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

Chapter: _____ Shirt Size: _____

AGE: _____ If Under 21 for rooming purposes. All Registrants

Affiliation: (Check all that apply)

_____ Member _____ Sweetheart _____ Rainbow _____ Advisor

_____ Squire _____ Job's Daughter _____ Chaperone (Must be 21 years of age)

Email Address: _____

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

Advisor's Signature: _____

Responsible Advisor/Chaperone: _____

(Please Print)

Desired Roommate 1. _____

2. _____

Back of the form MUST be completed by everyone.

Registration Fees and Deadlines

(See DeMolay website for credit card payment.)

(If you pay by credit card there will be a \$4.00 processing fee added to each registration.)

- ☐ Maryland DeMolay/Squires Only Pre-Registration - **\$80.00 (Prior to June 11th)**
- ☐ Advisor/Guest Registration (3 Day Conclave) – **\$145.00 (due by June 11th)**
- ☐ All registrations received **after June 11th \$180.00**
- ☐ Sunday Banquet Only - **\$35.00 (due June 23rd)**

NO REGISTRATIONS ACCEPTED AFTER JUNE 23rd

Make Checks Payable to: MSADC Conclave 2019
PO Box 724
Reisterstown, MD 21136

Information: Kenneth Kiessling 410-294-1551 or Alice Martinek 443-790-6048 amartinek@cityofbowie.org

Office use only

Cash: _____

Check: _____

Date Received: _____

Initials: _____

Permission Sheet

_____, a member of _____ Chapter
(Bethel, Assembly) Order of DeMolay, has my/our permission to travel
to Conclave being held at **Salisbury State University** in Salisbury,
Maryland on the Friday, July 12th, 2019 (1:00pm) to Sunday, July 14th,
2019 (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/chaperone 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

Emergency Number **(required)**: _____

Name: _____ Relationship: _____