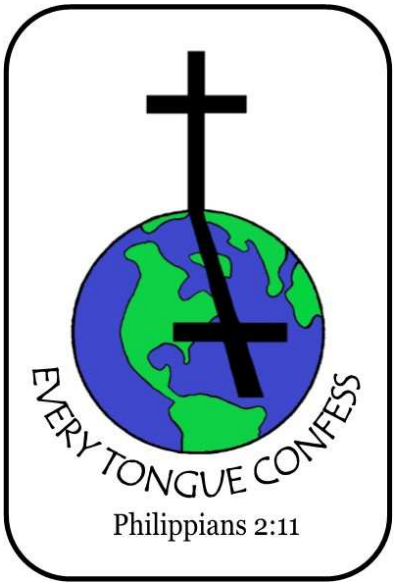
LWML Montana District Convention
April 20 – 22, 2018
First Lutheran Church—Missoula
2808 South Avenue West, Missoula, MT 59804



NAME_____

ADDRESS_____

CITY_____**ST**_____ **ZIP**_____

Phone_____ **Email**_____

( ) VOTING DELEGATE—(Pastor's Signature for **Delegates Only)**

_____

( ) LWML Member ( ) Guest ( ) Young Woman (ages 18-35)

( ) District Board Member ( ) Pastor ( ) Past LWML MT President

CHURCH_____CITY_____SOCIETY_____

( ) Mass Choir
Friday Rehearsal—4 -5:30 p.m.

( ) Servant Event @ First Lutheran
Friday, April 20, 1 to 4 p.m.

( ) Interpreter for the Deaf Needed ( ) Food Allergies_____

Early Registration (Includes Friday supper, Saturday lunch and banquet)	$75.00 _____
Registration, received after April 1, 2018	$85.00 _____
Banquet tickets (each additional one)	$20.00_____

Total Money Enclosed: $_____

Make checks payable to: LWML District Convention 2018

Send Registration form and check to:

Char Klofstad
908 Dixon Avenue
Missoula, MT 59801

Banquet Attendees: Please wear vintage hats or an entire vintage outfit.

Gifts From The ❤ **Heart:**

Mountain Home Montana – Infant items (diapers, wipes, formula, baby toys, etc.).
Orphan Grain Train – In addition to nice clothing and reading materials, Hygiene/Medical Kits are needed (new): 1 washcloth, 1 bath towel, 1 stick deodorant, 1 adult-size toothbrush, 1 sturdy comb, 1 bar of soap, and 6 band aids (see OGT website for wrapping instructions).

LWML HEALTH AND EMERGENCY INFORMATION FORM

Please complete this form and return with registration.

PERSONAL INFORMATION

Name _____ Date of Birth _____

Address _____ City _____ State _____ Zip_____

Home Telephone ( ) _____

EMERGENCY INFORMATION

Whom should we notify in case of an accident or medical emergency? (Please list two persons with different addresses who are not at the LWML meeting with you.)

Name _____ Name _____

Address _____ Address _____

_____ _____

Telephone ( ) _____ Telephone ( ) _____

Relationship _____ Relationship _____

MEDICAL INFORMATION

Insurance/HMO _____ Policy # _____

Medicare # (if applicable) _____ Policy # _____

Primary Physician's Name _____

Address _____

Telephone ( ) _____

Do you have any health conditions (e.g. allergies, chronic conditions, special circumstances, or medications) that should be known about before any emergency treatment? Explain:

_____

_____

Signature _____ **Date** _____