MADISONVILLE CHRYSALIS COMMUNITY
REGISTRATION FORM

PLEASE CIRCLE DESIRED WEEKEND March 22-24, 2019 November 29-December 1, 2019

PLEASE PROVIDE ALL THE INFORMATION REQUESTED – COMPLETE IN FULL!

TO BE FILLED OUT BY THE CANDIDATE: **HIGH SCHOOL GRADUATION YEAR**_____

NAME_____ PHONE_____

ADDRESS_____ CITY_____

STATE_____ ZIP_____ EMAIL ADDRESS_____

NAME FOR NAME TAG_____ SCHOOL_____

T-SHIRT SIZE_____

NAME OF CHURCH NOW ATTENDING_____ NONE_____

PASTOR'S NAME _____ ADDRESS_____ CITY_____

PARENTS NAME (S)_____ ADDRESS_____

CITY_____ STATE_____ ZIP_____ PHONE_____

HAVE YOUR PARENTS ATTENDED AN EMMAUS, BANQUET, OR CURSILLO WEEKEND?_____

HAS CHRYSALIS BEEN EXPLAINED TO YOU?_____

HAS THE FOLLOW-UP PROGRAM OF GROUP REUNION AND GATHERING BEEN EXPLAINED TO YOU?_____

STATE BRIEFLY WHY YOU WISH TO PARTICIPATE IN CHRYSALIS AND WHAT YOU EXPECT FROM IT_____

Total cost is $65. Please enclose a deposit of $20, which applies toward the expenses of the Chrysalis. The balance may be paid on the weekend. The deposit is not refundable unless there are no openings. The $65 applies towards the cost of lodging, food, and supplies. However, it does not cover the total cost. The cost for the 60-hour experience is dependent upon additional contributions made by persons interested in youth having this experience. Please make checks payable to: Madisonville Chrysalis. You will be notified of your acceptance. IMPORTANT: Please notify us IMMEDIATELY if you cannot come. Detailed information about arrival and housing will be sent. If you need financial aid, please indicate.

YES NO

YOUTH SIGNATURE_____ DATE_____

TO BE FILLED OUT BY PARENT OR GUARDIAN:_____has my/our permission to attend the Chrysalis Event. In the event of an emergency and if I/we cannot be reached by phone, the Chrysalis staff has permission to secure the services of licensed medical professionals to provide the care necessary, including anesthesia, for my child's well-being.

SIGNATURE OF PARENT OR GUARDIAN_____ PHONE_____

IF ABOVE CANNOT BE REACHED, PLEASE CALL_____ PHONE_____

PLEASE LIST ANY MEDICAL ALLERGIES, MEDICATIONS BEING TAKEN, MEDICAL PROBLEMS, SPECIAL DIET, OR OTHER PERTINENT INFORMATION_____

PLEASE COMPLETE THE FOLLOWING INFORMATION IN FULL

SPONSOR NAME_____ ADDRESS_____

CITY_____ STATE_____ ZIP_____ PHONE_____

NAME OF PERSON FILLING OUT REFERENCE FORM (ATTACHED PAGE)_____

ADDRESS_____ CITY_____ STATE_____ ZIP_____ PHONE_____

MAIL COMPLETED FORM TO:

MADISONVILLE CHRYSALIS COMMUNITY
C/O FIRST UNITED METHODIST CHURCH
200 EAST CENTER STREET
MADISONVILLE, KY 42431

QUESTIONS:
(270)-821-5734
chrysalis@m1umc.org

REVISED NOVEMBER 2018