Madisonville Chrysalis

PLEASE CIRCLE THE DESIRED WEEKEND November 20-22, 2026 March 19-21, 2027

PLEASE PROVIDE ALL THE INFORMATION REQUESTED – COMPLETE IN FULL

TO BE FILLED OUT BY THE CANDIDATE:

NAME _____ PHONE _____

ADDRESS _____ CITY _____

STATE _____ ZIP _____ EMAIL ADDRESS _____

NAME FOR NAME TAG _____ T-SHIRT SIZE _____

HIGH SCHOOL GRADUATION YEAR _____ SCHOOL _____

WHAT CHURCH DO YOU ATTEND? If none, please indicate. _____

MOTHERS NAME _____ FATHERS NAME _____

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 GROUP PROGRAM OF REUNION GROUPS BEEN EXPLAINED TO YOU? _____

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

_____

_____

_____

_____

_____

_____

_____

_____FLIP TO THE BACK PAGE

Total cost is $85. 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 $85 applies toward 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 THE 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.

PARENT OR GUARDIAN SIGNATURE _____ PHONE _____

IF ABOVE CAN NOT BE REACHED, PLEASE CALL _____ PHONE _____

PLEASE LIST ALL MEDICAL ALLERGIES, MEDICATIONS BEING TAKEN, MEDICAL PROBLEMS, SPECIAL DIET, OR OTHER PERTINENT INFORMATION: _____

_____

SPECIAL FOOD CONCERNS: _____

_____

PLEASE COMPLETE THE FOLLOWING INFORMATION IN FULL

SPONSOR NAME _____ PHONE _____

EMAIL _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

(Please complete the separate reference form and send it to the church, separately or with application.)

REFERENCE NAME _____ PHONE _____

ADDRESS _____

CITY _____ STATE _____ ZIP _____

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 Jan 2025