CROSS WINDS CHRYSALIS FLIGHT No. 52 APPLICATION
First United Methodist Church Wichita, Kansas
December 26-29, 2018

TO BE COMPLETED BY THE CANDIDATE
Chrysalis is open to youth who have finished their Freshman year of High School through college **Freshmen.**

Personal Information (please print clearly)

Name: _____

Preferred First Name (if different): _____

Address: _____

City:_____

State _____ Zip: _____

Phone (_____) _____

Gender:_____M _____F Age____Grade in Fall_____

Do you require special meals? (If yes, please explain:)

_____

_____

Do you have any health problems or disabilities that may effect your participation on the Chrysalis weekend? (explain)

_____

_____

Special Medications taken: Please attach a list of medications, dosages, and times taken.)

_____

Getting to Know You (please print)

Church Attending: _____

Youth Leader: _____

Church Phone: _____

In what religious/youth activities and/or community organizations are you currently active?: _____

_____

_____

Do you see yourself as: (check one)

_____Shy/Quiet _____Moderately Talkative

_____Always have something to say

Briefly state why you wish to be involved in a Chrysalis weekend.

_____

_____

_____

_____

_____

Cost of registration is $100 for each participant. Make checks payable to Cross Winds Chrysalis.
We request a deposit of $25 in advance with the balance of $75 to be paid the day of registration.
This deposit is not refundable unless the flight is full**. Scholarships are available. Check box if needed**. ☐
You will receive a notification of receipt of your application as soon as it is received. Additional information about what to bring and a map showing the location will be sent as the weekend approaches.

Return the completed application form to your sponsor. Please include the deposit of $25.

Emergency Medical Treatment authorization

I, _____, parent or legal guardian of _____ do hereby give my consent to the leadership of Cross Winds Chrysalis to act on my behalf for said minor in granting permission for evaluation or treatment of minor medical problems. I understand that, should a major medical problem arise, I will be notified by phone. In the event that I cannot be reached, I hereby give my consent to such medical treatment as deemed necessary, (including x-ray examinations and anesthesia) to said minor by a licensed physician or physicians. I certify that I have read and fully understand this authorization..

Signature of Parent or Guardian:_____ Date:_____

To be completed by the Sponsor

Sponsor Name: _____ Phone: _____

Address: _____ City: _____ State: ____Zip: _____

Email:_____

Sponsors return this form to: Curtis Current, Registrar, 7045 SW Indian Hills Rd., Auburn, KS 66402