



Team Application

Name: Mr/Mrs/Ms/Rev. _____

Address: _____ City: _____ State: _____ Zip _____

Home Phone(____) _____ Work Phone (____) _____ Cell/Pgr (____) _____

E-mail _____ Date of Birth _____ Occupation _____

Home Church _____ Other Ministry _____

Marital Status (Circle one) single married divorced widowed

Dates/# of your weekend _____ Location _____

Retreat (circle one) Chrysalis Emmaus Kairos

Have you served on a Chrysalis/Emmaus Team before yes no

If Yes, Indicate # of times for each position you have worked:

LD _____	ALD _____	Sacristan _____
Music _____	Head Cook _____	Kitchen _____
Asst. Head Cook _____	Table Leader _____	Agape _____
Board Liaison _____	Angel _____	Mime _____

Please indicate # of times you have given each talk:

(Youth)	(Adult)	(Clergy)
Ideals _____	Faith _____	God Designed You _____
Prodigal _____	Communication _____	God Denied _____
Christian Growth _____	Marriage _____	Means of Grace _____
Christian Action _____	Single Life _____	God Accepted _____
Next Steps _____	Priesthood _____	God Empowers _____

What would you like to do this Flight? _____

Have you prayed about it? _____

Why do you want to serve on Chrysalis? _____

Do you require a special diet? _____

By my signature, I will attend team meetings, pray for the weekend, pay my team fees, and perform assignments made by the LD with trust in God's love to lead me.

Signature _____ **Date** _____

Mail to: San Diego Chrysalis Community, Attn: Registrar, P.O. Box 502385, San Diego, Ca. 92199-2385

Applicants under the age of 18 must have a parent or guardian complete the following page, applicants over 18, please complete sections concerning Medical/Dietary needs on the following page.

**PARENT/GUARDIAN MUST COMPLETE THE FOLLOWING AUTHORIZATION FORM-----
-----UNDER 18 YEARS OF AGE-----**

_____ has my/our permission to attend the Chrysalis weekend.

In the event of emergency:

I (WE) THE UNDERSIGNED PARENT(S) OR GUARDIAN(S) OF _____
A MINOR, DO HEREBY AUTHORIZE AND CONSENT TO ANY X-RAY EXAMINATION,
ANESTHESIA, MEDICAL OR SURGICAL DIAGNOSES OR TREATMENT UNDER THE GENERAL OR
SPECIFIC SUPERVISION OF ANY MEMBER OF THE MEDICAL STAFF AND EMERGENCY STAFF
LICENSED UNDER THE PROVISIONS OF THE MEDICINE PRACTICE ACT, OR A DENTIST
LICENSED UNDER THE PROVISIONS OF THE DENTAL PRACTICE ACT, OR THE STAFF OF ANY
ACUTE GENERAL HOSPITAL HOLDING A CURRENT LICENSE FROM THE STATE OF CALIFORNIA,
DEPARTMENT OF PUBLIC HEALTH, TO OPERATE A HOSPITAL. IT IS UNDERSTOOD THAT THIS
AUTHORIZATION IS GIVEN IN ADVANCE OF ANY SPECIFIC DIAGNOSIS, TREATMENT OR
HOSPITAL CARE BEING REQUIRED, BUT IS GIVEN TO PROVIDE AUTHORITY AND POWER TO
RENDER CARE WHICH THE AFOREMENTIONED PHYSICIAN, IN THE EXERCISE OF HIS BEST
JUDGMENT, MAY DEEM ADVISABLE. IT IS UNDERSTOOD THAT EFFORT SHALL BE MADE TO
CONTACT THE UNDERSIGNED PRIOR TO RENDERING TREATMENT TO THE PATIENT, BUT THAT
ANY OF THE ABOVE TREATMENT WILL NOT BE WITHHELD IF THE UNDERSIGNED CANNOT BE
REACHED. THIS AUTHORIZATION IS GIVEN PURSUANT TO THE PROVISIONS OF SECTION 25.8
OF THE CIVIL CODE OF CALIFORNIA.

List any RESTRICTIONS: _____

List any and all Dietary restrictions _____

This consent shall remain in effect until Date _____

SIGNATURE OF PARENT(S) OR GUARDIAN(S)

DATE _____

DATE _____

In the event you need to be reached during the weekend:

Phone () (Home) () (.Office) () (Cellular) ()

() emergency#

PLEASE LIST ANY ALLERGIES, MEDICATIONS BEING TAKEN, MEDICAL PROBLEMS, SPECIAL
NEEDS, OR OTHER PERTINENT INFORMATION:

Include times medicine is taken. _____

A \$15.00 deposit is requested at the time the application is turned in. This is non-refundable; please make
checks payable to San Diego Chrysalis. The balance of \$60.00 is due one week before the flight. All
applications must be turned in by the dates set by the Chrysalis board. There is **NO SMOKING** allowed at
anytime while participating in Chrysalis activities. For those under 18 years of age, parental authorization must
be filled out.

Deposit \$	Date	Balance \$	Date
Cash	Check#	Cash	Check#

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