Chrysalis

Cornerstone Chrysalis Community
*Request for **Candidate** Reservation*

TO BE COMPLETED BY CANDIDATE (Please type or print legibly)

NAME	TELEPHONE NUMBER
	( ) -

ADDRESS	CITY	STATE	ZIP

BIRTHDATE	AGE / GRADE	SEX	E-Mail Address
/ /	/	M / F	

SCHOOL YOU ATTEND: ____

CHURCH YOU ATTEND: ____

PASTOR NAME: ______________________________**PHONE (_______)_______-___________**

RELIGIOUS/COMMUNITY ORGANIZATIONS: ______________________________

Has Chrysalis been explained to you? ________ **The follow-up program?** ________

State briefly why you wish to participate in Chrysalis and what you expect:

Do you need Scholarship Assistance? (circle one) YES / NO

REQUIRED SIGNATURES:

____ **DATE** ____________________
CANDIDATE SIGNATURE

________________________________/______________________ **PHONE (_____)______-_______**
SPONSOR(S) SIGNATURE PRINT NAME

________________________________ / ______________________ / ________ / ________________
Sponsor(s) Address City State Zip

Please enclose a pre-registration deposit of $35.00. This will be applied toward your contribution of $75.00 which offsets the expense of the weekend. Make checks payable to Cornerstone Chrysalis. You will be notified of your acceptance and the dates of your weekend. Please notify us IMMEDIATELY if you cannot attend since there may be a waiting list.

PLEASE MAIL TO:

Registrar - Cornerstone Chrysalis
PO Box 834
Tehachapi, CA. 93581-0834

TO BE COMPLETED BY PARENT OR GUARDIAN:

____ has my/our permission to attend the Chrysalis program. In the event of emergency, my authorization for emergency treatment is provided below.

I (WE) the undersigned parent(s) or guardian(s) of ______________________________________, a minor, do hereby authorize and consent to any X-Ray examination, anesthetic, medical or surgical diagnosis or treatment rendered under the general or special 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 it is given to provide authority and power to render care which the aforementioned Physician, in the exercise of his best judgement, 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 the State of California. I (We) do forever release, acquit, discharge, and covenant to hold harmless the High Desert Chrysalis Community, their affiliated organizations, directors, staff, volunteers and guests from any and all actions, causes of action, claims, demands, costs, loss of services or income, expenses and compensation, on account of, or in any way growing out of, any and all known and unknown personal injuries and property damage which may occur as a result of participation in this program. This consent shall remain in effect indefinitely unless otherwise specified.

SIGNATURE OF PARENT(S) OR GUARDIAN(S):

____________________________________/___________________________ Date _______________
Father (or legal guardian) Print Name

____________________________________/___________________________ Date _______________
Mother (or legal guardian) Print Name

In the event that your child must return home before the program is over, or in case of a medical emergency, please provide the telephone numbers where you can be reached.

Phone (______)______-__________ Alternate Emergency Phone (______)______-_________

Please list any allergies, medications being taken, medical problems, special diet, or other pertinent information or restrictions:

____

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____

FOR OFFICE USE ONLY

Received		SL Sent		Fees Paid	
Approved		PL Sent		Paid By	

Comments – Notes:

Chrysalis

Cornerstone Chrysalis Community
Medical/Liability Release

I do hereby authorize and consent to any X-Ray examination, anesthetic, medical or surgical diagnosis or treatment rendered under the general or special 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 it is given to provide authority and power to render care which the aforementioned Physician, in the exercise of his best judgement, 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 the State of California. I (We) do forever release, acquit, discharge, and covenant to hold harmless the High Desert Chrysalis Community, their affiliated organizations, directors, staff, volunteers and guests from any and all actions, causes of action, claims, demands, costs, loss of services, expenses and compensation, on account of, or in any way growing out of, any and all known and unknown personal injuries and property damage which may occur as a result of participation in this program. This consent shall remain in effect indefinitely unless otherwise specified.

TO BE COMPLETED BY PARENT OR GUARDIAN (if applicant is under 18):

____ has my/our permission to attend the Chrysalis program. In the event of emergency, my authorization for emergency treatment is provided above.

SIGNATURES:

____________________________________/___________________________ Date _______________
Participant's Signature   Print Name

____________________________________/___________________________ Date _______________
Parent or Guardian Signature   Print Name
(if applicant is under 18)

In the event that the above named participant must return home before the program is over, or in case of a medical emergency, please provide the telephone number(s) where an emergency contact may be reached.

Emergency Contact Person(s) Name: ____

Phone #(s): (_______)________-________   (_______)________-________

Please list any allergies, medications being taken, medical problems, special diet, or other pertinent information or restrictions:

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