CHILD EVANGELISM FELLOWSHIP® OF ARKANSAS INC.

CHRISTIAN YOUTH IN ACTION® (CYIA®)

10421 W. Markham St., Ste. 100, Little Rock, AR 72205

Gary Atkins, State Director 918-868-4444 cefofarkansas@gmail.com website: www.cefark.com

CYIA TRAINING APPLICATION

This is an "Application" only and does not guarantee you will be selected for CYIA. If approved, you will receive a Letter of Acceptance from the CYIA Registrar. This application must be postmarked no later than May 5, 2025.

Name ____ Date of Birth ______/ ______/ ______

First Last

Address ____ T-shirt Size______________________

Street

____ Sex: M ___ F ___

City State Zip

E-mail ____ Phone (_______) ______________________

Parent or Guardians' Names ____

Parent or Guardians' Work Phone ______________________________ Cell Phone ______________________________

Work Phone ______________________________ Cell Phone ______________________________

The *5-Day Club®* teaching kit we will use comes in two different Bible translations. Do you prefer: KJV____ ESV____

BACKGROUND AND EXPERIENCE:

1. On a separate sheet of paper:
   a) Give a brief account of your Christian testimony.
   b) State on what you base your salvation.
   c) Tell why you want to take part in CYIA™ and how you plan to use the CYIA™ training in the future.

2. Church Affiliation ____

3. School Name and current year in school ____
   (please indicate if you are home educated)

PERSONAL REFERENCES:

Give the name and address of two adult Christian friends and your pastor.

NAME ADDRESS (Street, City, Zip) PHONE

1. ____

2. ____

3. ____

PRAYER PARTNERS: (Those whom you have asked to pray for you during CYIA)

NAME ADDRESS (Street, City, Zip) PHONE

1. ____

2. ____

3. ____

4. ____

5. ____

CYIA Ministry Plan

After you complete *CYIA* how do you plan to put this training to work for God?

□ *CEF® 5-Day Club®* □ *CEF Good News Club®* □ *CEF* Christmas Party Club

□ Church ministry:____

____

□ Other: ____

____

Check the weeks that you will be available to teach with *CEF* this summer. *5-Day Clubs* will be scheduled according to the following weeks that you check below:

( ) June 9-13 ( ) June 16-20 ( ) June 23-27 ( ) June 30-July 3 ( ) July 7-11
( ) July 14-18 ( ) July 21-25 ( ) July 28-August 1 ( ) August 4-8 ( ) August 11-15

Please check ways in which you would be willing to teach or assist in other ministries:

( ) Camp ( ) Fair Ministry/outreach at community events

Do you have a driver's license? YES or NO

Is there someone in your family or church who would assist with transportation? YES or NO

If yes, name and phone number ____

NOTE: APPLICANT MUST SIGN ONCE BELOW. PARENT or GUARDIAN MUST SIGN IF APPLICANT IS UNDER 18

PLEASE ANSWER THE FOLLOWING QUESTIONS WITH A "YES" OR "NO".

1. I am willing to cheerfully follow the direction of those over me. ________
2. I have read the CYIA™ booklet including the standards of conduct and appropriate dress and will abide by it. ________
3. I feel my life is in order and my heart and mind and soul will be focused on God and learning how to better share the Gospel of Jesus Christ with children. _______

XAPPLICANT'S SIGNATURE ____ **DATE** ______________

I have reviewed this application and will help my teenager in every possible way to be an effective servant for the Lord. (Parent or guardian is required to sign if applicant is under 18.)

XPARENT or GUARDIAN SIGNATURE ____ **DATE** _____________

(Please call if you have any questions or don't understand the application process. We are happy to answer any concerns.)

Please submit this application, including Medical Release and Worker's Compliance Agreement, to:

Child Evangelism Fellowship
CYIA REGISTRAR
10421 W Markham St, Suite 100
Little Rock, AR 72205

Questions? Contact: Jean Atkins
CEFofArkansas@gmail.com
(918) 868-7722 (mbl / text)

Office Use Only
Paid _______________
Due ________________
Letter sent ___________

Medical Release and Permission Form

Effective dates: January 1-December 31, 2025

To be completed by parent/guardian

Personal Information **Please print in ink.**

Name: ____
Last First MI

Age: ______ Date of Birth: ____/____/____ Grade in school: _________ Sex: M ___ F ___

Home Address: ____

City: ______________ State: _______ Zip: ________ E-mail: _________________________

Home Ph.: (______) ________________ Student Cell Ph.: (______) ___________________

Mother's Name: ____

Day Ph.: (____)__________ Evening Ph.:(____)___________ Cell Ph.:(____)____________

Father's Name: ____

Day Ph.: (____)__________ Evening Ph.:(____)___________ Cell Ph.:(____)____________

Emergency contact person: _______________________Relationship:_________________

Day Ph.: (____)__________ Evening Ph.:(____)___________ Cell Ph.:(____)____________

Medical Insurance Company: ______________________________________

Policy#:__________________________ Subscriber: _________________________________

Physician:______________________________ Office Phone: (_____) __________________

Dentist: ________________________________ Office Phone: (_____) __________________

Over-the-Counter Medications

Carefully review the following list of over-the-counter medications that will be kept on hand for medical needs while at CYIA. These items will be given out by a staff member only if necessary. Circle any that you do **not** want your child to have.

Tylenol	Ibuprofen	Midol	Aspirin	Zyrtec
Cough drops	Cough Syrup	Benadryl	Sudafed	Neosporin
Calamine Lotion	Antacid Tablets	Anti-itch Cream	Rubbing Alcohol	Band-Aids
Hydrogen Peroxide	Pepto-Bismol			

Medical History

Check the following areas of concern for your child. If necessary, add another page with details.

1. Date of last tetanus shot: ____________________
2. Does your child wear Glasses? _________ Contacts? ___________
3. Does your child suffer from, ever experienced, or is currently being treated for any of the following?

____ Asthma ____ Epilepsy ____Heart Trouble ____ Diabetes

____Headaches ____Physical Handicaps _____Frequently Upset Stomach ____ADHD

_____ADD ____Depression _____Lyme Disease

Please explain:

4. Does your child have any learning challenges that we need to be aware of to help him/her be successful at CYIA training (if attending)? Please Explain:

5. Does your child have allergies to?

    ____ Pollen ____ Medication ____ Food ____ Insect Bites ____ Latex

    Please explain:

6. Please list any major illnesses your child has experienced during the last year.

7. Please list all medications your child is currently taking and the reason for taking medications.

8. Should your child's activities be restricted for any reason? If so, please explain.

Parental Permission Form

I/We give permission to use photos of my/our child for CEF Ministry publicity.

I/We the undersigned have legal custody of the child named above, a minor, and have given our consent to him/her to attend Christian Youth in Action 2025 and other CEF activities throughout the year.

I/We acknowledge that all pertinent information concerning any medical, emotional or learning challenges have been made known that possibly could affect my child's involvement in the ministry of CEF.

I/We understand that there are inherent risks involved in any ministry, or recreational/athletic event, and I/we hereby release Child Evangelism Fellowship, its employees or volunteer workers from any and all liability for any injury, loss, or damage to person or property that may occur during the course of my/our child's involvement.

In the event that he/she is injured and requires the attention of a doctor, I/we consent to any reasonable medical treatment as deemed necessary by a licensed physician. In the event treatment is required from a physician and/or hospital personnel designated by CEF, I/we agree to hold such person free and harmless of any claims, demands, or suits for damages arising from the giving of such consent.

I/We also acknowledge that I/we will be ultimately responsible for the cost of any medical care should the cost of that medical care not be reimbursed by the health insurance provider. Further, I/we affirm that the health insurance information provided above is accurate at this date and will, to the best of my/our knowledge, still be in force for the child named above.

I/We also agree to bring my/our child home at my/our own expense should they become ill or if deemed necessary by the CEF staff member.

Signed: ______________________________________Print Name: ________________________________

Parent/Guardian

Date:_____________________ ***PLEASE ATTACH A COPY OF INSURANCE CARD***