



Frontiersmen Camping Fellowship Volunteer Chapter Tennessee District Royal Rangers



September 24-26, 2020

REGISTRATION APPLICATION PLEASE TYPE OR PRINT

Name: _____ Birthdate: M _____ D _____ Y _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email: _____

Home Phone Number: _____ Business Phone Number: _____

Church: _____ Church Phone Number: _____

Church Address: _____

City: _____ State: _____ Zip Code: _____

Outpost # _____ District: _____ Section: _____

FCF Level: ___ Frontiersman ___ Buckskin ___ Wilderness

FCF Name: _____

Registration Fees: Check one: ___ Old Timer \$30 ___ Young Buck \$25 (Deduct \$5 per person for early registration)

Early registration deadline is: 8/1/2020

Annual Dues: Check one: ___ Annual Dues \$25 ___ Jr. Lifetime Dues \$50 ___ Lifetime Dues \$150

Total Enclosed: _____ *Make Checks Payable to FCF Volunteer Chapter*

Send Application and Fees to:

Doug "Talking Bull" Kave, FCF Scribe
426 Woodview Rd.
Byhalia, MS 38611
E-mail: commanderbacon64@gmail.com
Phone: (901) 412-6658

Chapter Use Only:

Date received	Amount paid	Date information letter mailed



Frontiersmen Camping Fellowship
Volunteer Chapter
Tennessee District Royal Rangers



Pastors Certification for Church Workers - FCF Trace Camp

If the participant will be 18 or older at the time of the FCF Trace Camp, the participant's pastor must sign this form.

Adult (18+) Pastor's Certification for a Church Worker:

I am personally acquainted with the adult applicant, and in my opinion, he is a competent and qualified youth worker. I know of no facts or allegations that raise any questions concerning his suitability for working with minors in any Royal Rangers activity. The church has on file the applicants screening form. Adult leaders are considered 18 years of age or older.

Pastor's Signature: _____ Date: _____

Phone Number: _____ Email: _____



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MEDICAL RELEASE FORM

(Please complete one copy for each boy attending FCF Trace)

NAME OF CAMPER: _____ District: _____

ADDRESS: _____

CITY: _____ ZIP _____ DOB _____

AGE: _____ PARENT'S/GUARDIAN'S NAME: _____

CHURCH: _____ OUTPOST NUMBER: _____

Parent Release to Attend the FCF Trace Camp

I hereby authorize _____ (Ranger's/boy's name) to attend the FCF Trace Camp. I understand the arrangements and feel that adequate precautions for the safety of my child have been made and will continue to be taken. I will not hold the local church, its leaders, the FCF Volunteer Chapter staff, or the General Council of the Assemblies of God responsible for accidents. I understand that my personal insurance will be the primary carrier in case of an emergency needing professional care. I understand that a First Aid Station will be on the site with a qualified person on duty.

Insurance company name/policy # Signature of parent or guardian Date

PHYSICIAN'S AUTHORIZATION FOR EMERGENCY MEDICAL TREATMENT

The purpose of this section is for parents or guardians to authorize emergency treatment for their child in case of illness or injury while in the custody of Leaders attending the FCF Trace Camp.

This section must be completed and signed to provide for emergency care.

I _____ from _____,
(Parent or guardian) (City) (State)

the _____ of _____, a minor who is attending the
(Father, Mother, Legal guardian) (Child's name)

FCF Trace Camp, do give consent beforehand (in the event that all reasonable attempts to contact me or _____ have been unsuccessful) for the administration of any treatment
(Alternate consenting adult)

necessary by a licensed physician or dentist.

() _____ () _____
Phone number Alternate phone number - cell, business, etc.

Parent or guardian signature Date



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HEALTH HISTORY

This form should be filled out by the parent or guardian. Answer **“Yes”** or **“No”** to **all** of the following. Briefly explain all “Yes” answers under the “MEDICAL REMARKS” Section.

- | | | |
|--|------------------------------|-----------------------------|
| Sinus condition | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Ear problem (tubes, etc.) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Lung problem | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Heart problem | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Blood pressure problem | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Allergy or asthma | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Fainting or dizzy spells | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Shortness of breath | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Skin infection | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hearing difficulty | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Bad eyesight | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Wears contact lenses | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any medical care in past year | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any surgery within past year | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hepatitis, TB, or other communicable disease | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any exposure to infections within last three weeks | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any disorder preventing strenuous activity | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Taking prescription medications or drugs | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any reaction to drugs or medications: list type | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any special diet requirements | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Any physical limitations needing special attention | <input type="checkbox"/> Yes | <input type="checkbox"/> No |

MEDICAL REMARKS

LAST KNOWN DATE OF INOCULATION OR VACCINATION AGAINST

TETANUS	SMALLPOX	MEASLES	TYPHOID	DIPHTHERIA	POLIO	TB
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List any restrictions from full activities at this event:



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Knife & Hawk Throwing and Black Powder Permission Form

I am the parent or guardian of _____ who is a member of the Royal Rangers Program. I give, him permission to sell, trade, give, receive, or barter and have in his possession during any FCF event, any knife and hawk throwing or black powder firearm as is appropriate for this type of historical reenactment activity. Please consider this document as written consent for my son to participate in any of the Frontiersmen Camping Fellowship activities which include black powder loading and shooting, knife and hawk throwing, flint and steel - fire starting, frontiersmen crafts and workshop classes, and any other activities conducted.

Signature of parent or guardian

Date

If you do not want your son, _____ participating in any of the above activities please list: _____

Signature of parent or guardian

Date

If you are under the age of 18, you must have this form signed by your parent or guardian in order to participate in the above-mentioned activities at the FCF Trace Camp.

Parents, please complete:

Name of minor _____

Name of Parent completing form: _____

Address: _____

City State Zip _____

Homephone: _____ Work Phone: _____

Age _____ Birth date of minor _____

Any Information we should know about:

