Frontiersmen Camping Fellowship
Volunteer Chapter
Tennessee District Royal Rangers

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: _____

Early Registration Fees: Check one:_____Old Timer $25 _____Young Buck $20

Registration Fees: Check one:_____Old Timer $30 _____Young Buck $25

Annual Dues: Check one:_____Annual Dues $25 _____Jr. Lifetime Dues $50 _____ Lifetime Dues $150

Total Enclosed:_____ *Make Checks Payable to TN Ministries*

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

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

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

MEDICAL REMARKS

_____

_____

_____

_____

LAST KNOWN DATE OF INOCULATION OR VACCINATION AGAINST

TETANUS	SMALLPOX	MEASLES	TYPHOID	DIPHTHERIA	POLIO	TB

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 _____

Home phone:_____ Work Phone: _____

Age_____ Birth date of minor _____

Any Information we should know about:

_____

_____

_____