



# 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: \_\_\_\_\_

Royal Ranger Alumni: \_\_\_\_\_

FCF Level: \_\_\_ Frontiersman \_\_\_ Buckskin \_\_\_ Wilderness

FCF Name: \_\_\_\_\_

Registration Fees: Check one: \_\_\_ Old Timer \$30 \_\_\_ Young Buck \$25

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

\_\_\_ Life Member

Total Enclosed: \_\_\_\_\_ *Make Checks Payable to "Friends of Rangers"*

Bring all paperwork and fees with you to the camp.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### 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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## 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

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#### 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 \_\_\_\_\_

Homephone: \_\_\_\_\_

Work Phone: \_\_\_\_\_

Age \_\_\_\_\_ Birth date of minor \_\_\_\_\_

Any Information we should know about:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_