Frontiersman Camping Fellowship

Knife and Black Powder
Permission - Medical Information 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 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 Frontiersman 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.
I will hold harmless any and all leaders or officers of any unforeseen accidents, even though great care for safety is always taken.

_____ _____
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 Trace, and or Rendezvous.

Parent please complete:

Name of minor _____
Name of Parent completing form: _____
Address: _____
City: _____
State _____ Zip _____
Home phone and work phone (____) h_____ w_____
Age _____ Birth date of minor _____

Any Information we should know about:_____
_____
_____

You must have the Medical Form Information Completed and signed
by parent or guardian on the back side of this form.

Individual Medical Form

HEALTH HISTORY AND MEDICAL PERMISSION FORM
One Form Per Person (Must have a copy of this on every boy when you register at event/camp)

PLEASE PRINT

Name_____

Address_____

City_____

State _____Zip_____

Phone ( ) _____
Date of Birth _____
Ranger Outpost # _____

NOTIFY IN AN EMERGENCY:

Name_____

Address_____

City _____

State _____Zip_____

Emergency Phone ( ) _____
Relationship _____

Church Name _____ City _____

PLEASE Provide additional information about any items (checked Yes) to Right

_____
_____
_____
_____
_____
_____
_____

Have You Ever Been Treated For Any Of Following? (If Yes Check ❑)

- ❑ Heart disease
- ❑ Asthma
- ❑ Seizures
- ❑ Allergies
- ❑ High Blood pressure
- ❑ Bronchitis
- ❑ Diabetes

Please Identify Any Physical Impairments or Limitations:

_____

Date of Last Tetanus Booster ____ 19_____

Do You Wear: (If Yes Check q)

- ❑ Contacts
- ❑ Glasses
- ❑ Dental appliance

Please List Any Medications Being taken

_____

IN THE EVENT HOSPITALIZATION IS NEEDED, PLEASE FILL IN

Name of Insured:_____
(POLICY HOLDER)

MEDICAL / HOSPITAL INSURANCE
COMPANY:_____

POLICY OR CERTIFICATE
NUMBER:_____

EMPLOYER:_____ EMPLOYER'S GROUP _____
NUMBER:_____

In Case of an Emergency, I Hereby Give Permission to the Physician to Render Treatment. Should The Physician Deem it Necessary, I Authorize Hospitalization, Anesthesia, Surgery or Injection of Medication.

_____ _____ _____
Signature (Parent, if Minor) Date

Name of Person to Contact (Commander or Adult) on Premises for Information:

_____ _____