

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

NOTIFY IN AN EMERGENCY:

Name _____ Name _____

Address _____ Address _____

City _____ City _____

State _____ Zip _____ State _____ Zip _____

Phone () _____ Emergency Phone () _____

Date of Birth _____ Relationship _____

Ranger Outpost # _____

Church Name _____ City _____

PLEASE Provide additional information

Have You Ever Been Treated For Any Of

about any items (checked Yes) to Right Following? (If Yes Check)

- | | |
|--|-------------------------------------|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> High Blood pressure | <input type="checkbox"/> Bronchitis |
| | <input type="checkbox"/> 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:
