Frontiersman Camping Fellowship

Young Bucks - Knife and Black Powder
Permission / Medical Information Form

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.

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

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, two parts to this form.

Individual Medical Form – Young Bucks

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

Date of Last Tetanus Booster ____ _____

Please Identify Any Physical Impairments or Limitations:
____

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:

____