



# Frontiersmen Camping Fellowship

## APPLICATION FOR MEMBERSHIP

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age \_\_\_\_\_  
(Last) (First)

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Church Name: \_\_\_\_\_

### PRESENT ROYAL RANGER POSITION

- Commander       SR. Commander       LT. Commander       Outpost Council  
 Pastor       Outpost Chaplin       Royal Ranger (11 years or older)

### BASIC REQUIREMENTS FOR MEMBERSHIP

1. Be active in a local outpost
2. Have a genuine interest in the camping aspect of Royal Rangers
3. Agree to uphold the standards and policies of F.C.F.
4. Boys and leaders must have earned all 8 patches of the Trail of the Grizzly
5. Leaders must also complete the Royal Ranger Basic LTA module

You will be required to qualify for admission into F.C.F. by demonstrating your ability in Pre-1840 skills at the Big Adventure. This application, along with a 100 word statement on why you wish to be a member of F.C.F., A recommendation from your pastor and commander with a \$25.00 fee **must be submitted by March 31<sup>st</sup>**, any applications postmarked **after March 31<sup>st</sup>** will need to add a \$5.00 late fee.

**STATEMENT OF PURPOSE:** “Realizing the goal of the Royal Ranger ministry is to reach, teach, and keep boys for our Lord Jesus Christ and that the frontiersmen camping fellowship upholds this area in its fullness and agreeing to live by the ideal set forth in the above requirement, I hereby submit my application”

Applicant’s Signature \_\_\_\_\_ Date \_\_\_\_\_

Recommendation:

Pastor’s Signature \_\_\_\_\_ Date \_\_\_\_\_

Commander’s Signature \_\_\_\_\_ Date \_\_\_\_\_

MAIL COMPLETED APPLICATION, 100 WORD STATEMENTS, AND FEE **(NO CASH MAKE CHECK OR MONEY ORDER PAYABLE TO KENTUCKY ASSEMBLY OF GOD FCF)**

MAIL TO:

**Richard Hildreth, 9126 Alexandria Pike,  
Alexandria, Ky. 41001**

**Personal Medical Record**

**Insurance Information**

Applicant's Full Name

Health Insurance Company's Name

**In case of emergency please notify:**

Last Name *(please print)*

First Name

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Policy Number

Certificate Number

Effective date of coverage

Health Insurance Company's Phone Number

Daytime Contact Phone Number

Evening Contact Phone Number

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**General Information:**

*A Personal Medical Record must be completed by each applicant for participation. Records for minors (under age 18) must include a parent or guardian's signature. Royal Rangers office reserves the right to accept or reject any person based upon his medical health.*

**Health History** To be completed by the applicant (if over 18) or by a parent/guardian if the applicant is a minor (under age 18). Has the applicant experienced the following? Check "Yes" or "No."

Sinus condition	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	Shortness of breath	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	Exposed to infectious:																								
Ear problem	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	Skin infection	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	Disease past 3 weeks	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	Hepatitis past 6 months	<input type="checkbox"/>	yes	<input type="checkbox"/>	no															
Lung problem	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	Hearing difficulty	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	Any disorder preventing strenuous activity?	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	Taking prescription medicine?	<input type="checkbox"/>	yes	<input type="checkbox"/>	no															
Heart trouble	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	Bad eyesight	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	Any reaction to drugs or medicine or any type?	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	Special diet required?	<input type="checkbox"/>	yes	<input type="checkbox"/>	no															
High blood	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	Wear contact lenses	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	Give latest date of inoculation or vaccination against following:																								
Allergy-Asthma	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	Any medical care in the past year?	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	Date		Date																						
Fainting or dizzy	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	Any surgery within past year?	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	Tetanus	<input type="text"/>	Small Pox	<input type="text"/>	Measles	<input type="text"/>	Typhoid	<input type="text"/>	Diphtheria	<input type="text"/>	Polio	<input type="text"/>													
Diabetes	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	Birth Date										Height										Weight									
Appendix	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	<input type="text"/>										<input type="text"/>										<input type="text"/>									

Food or drug allergies \_\_\_\_\_

I am currently taking the following medications \_\_\_\_\_

Remarks and medical facts: \_\_\_\_\_

Special dietary \_\_\_\_\_

Activity Restrictions \_\_\_\_\_

Parent/Guardian's Name (Please Print)

( )

Parent/Guardian's Area Code and Phone Number

Parent / Guardian's Address

City State Zip

**Parent/Legal Guardian Consent & Model Release** *(Required for all applicants under 18 years of age)* I, the undersigned, as parent or legal guardian of the above named minor do hereby consent to his participation in this event and authorize the use of emergency medical care at the discretion of the adult event leadership. I further acknowledge my understanding that media footage, including audio, video and photos, may be recorded at this event for future promotional use and hereby consent to the use of such items containing images of my child in any form and relinquish all rights of ownership or compensation. It is further understood that acceptance of these terms is a condition of my child's participation in this event.

Print Complete Name of Minor \_\_\_\_\_ ✕ Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**Pastor's Certification** *(Required for all applicants 18 years of age or older)* I, the undersigned, as Pastor of the above named adult participant do hereby acknowledge that the individual has been properly screened and approved for children or youth work in our church and provide my unqualified endorsement to his/her participation in this event.

✕ \_\_\_\_\_ Pastor's Signature \_\_\_\_\_ Date \_\_\_\_\_

**Applicant's Signature** *(Required for all applicants)* I, the undersigned, hereby acknowledge that to the best of my knowledge, I qualify for participation in this event and do hereby agree to abide by the rules and standards established for this event by its appointed leadership. I acknowledge that the information provided on my Personal Medical Record is true and correct and I consent to the administration of emergency medical treatment at the discretion of the event leadership. I further acknowledge my understanding that media footage, including audio, video and photos, may be recorded at the event for future promotional use and hereby consent to the use of such items containing images of me in any form and relinquish all rights of ownership or compensation.

✕ \_\_\_\_\_ Applicant Signature \_\_\_\_\_ Date \_\_\_\_\_

Required Release Signatures



# Frontiersmen Camping Fellowship

## Knife 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 or black powder firearm as in appropriate for this type of historical reenactment activity.

Pleas 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 craft 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 any FCF function.

Parents please complete:

Name of minor \_\_\_\_\_

Name of Parent completing form: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone and work phone: Home \_\_\_\_\_ Work \_\_\_\_\_

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

Any information we should know about: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_