BIG ADVENTURE

April 15th – 17th
Glasgow, KY

Registration Sheet for FCF Members

Personal Information (Please Print Clearly)

LAST NAME *(PLEASE PRINT)* MIDDLE INITIAL FIRST NAME

MAILING ADDRESS *(Street or R.F.D.)*

CITY STATE ZIP CODE

EMAIL ADDRESS *(if available)*

FCF ☐ **Frontiermen** ☐ **Buckskin** ☐ **Wilderness**

Guest Of: _____

○ FCF Young Buck (under 18)
○ FCF Old Timer (18 + older)

_____
HOME PHONE NUMBER + AREA CODE

_____
WORK PHONE NUMBER + AREA CODE

_____
CELL # + AREA CODE *(if available)*

Church Information

CHURCH NAME

CHURCH ADDRESS *(Street or R.F.D.)*

CITY STATE ZIP CODE

EMAIL ADDRESS *(if available)*

_____ _____
DISTRICT *(Abbreviate as needed)* OUTPOST #

_____
CHURCH PHONE + AREA CODE

_____
CHURCH FAX + AREA CODE

Personal Medical Record

Applicant's Full Name

In case of emergency please notify:

Last Name *(please print)* First Name

Daytime Contact Phone Number

Evening Contact Phone Number

Insurance Information

Health Insurance Company's Name

Policy Number

Certificate Number

Effective date of coverage

Health Insurance Company's Phone Number

General Information:

A Personal Medical Record must be completed by each applicant for participation. Records for minors (under age18) 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	☐	yes	☐	no	Shortness of breath	☐	yes	☐	no	Exposed to infectious:					
Ear problem	☐	yes	☐	no	Skin infection	☐	yes	☐	no	Disease past 3 weeks	☐	yes	☐	no	
Lung problem	☐	yes	☐	no	Hearing difficulty	☐	yes	☐	no	Hepatitis past 6 months	☐	yes	☐	no	
Heart trouble	☐	yes	☐	no	Bad eyesight	☐	yes	☐	no	Any disorder preventing					
High blood	☐	yes	☐	no	Wear contact lenses	☐	yes	☐	no	strenuous activity?	☐	yes	☐	no	
Allergy-Asthma	☐	yes	☐	no	Any medical care in the					Taking prescription					
Fainting or dizzy	☐	yes	☐	no	past year?	☐	yes	☐	no	medicine?	☐	yes	☐	no	
Diabetes	☐	yes	☐	no	Any surgery within past					Any reaction to drugs or medicine					
Appendix	☐	yes	☐	no	year?	☐	yes	☐	no	or any type?	☐	yes	☐	no	
										Special diet required?	☐	yes	☐	no	

Food or drug allergies

I am currently taking the following medications

Remarks and medical facts:

Special dietary

Activity Restrictions

Give latest date of inoculation or vaccination against following:

	Date		Date
Tetanus		Small Pox	
Measles		Typhoid	
Diphtheria		Polio	

Birth Date	Height	Weight

Parent/Guardian's Name (Please Print)

( )

Parent/Guardian's Area Code and Phone Number

Parent / Guardian's Address

City State Zip

Required Release

Signatures

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