# Eagle Rock Adventure Camp

Eagle Rock, MO

**Check camp preference**

## ☐ June 26-July 1, 2005 **or** ☐ July 24-29, 2005

## Camp Fee $200

**Indicate order of track preference. (1st-5th)**

_____ **Track A: (Rappelling, High Ropes, Low Ropes, Rock Climbing)**
_____ **Track B: (Mountain Biking, Paintball)**
_____ **Track C: (Shooting Safety, BB-Gun, Air Rifle, Archery)**
_____ **Track D: (Smallbore Rifle, Blackpowder Rifle, Safety & Shooting)**
_____ **Track E: (Horsemanship, Archery, Paintball)**

Tracks (limited to 20) are determined by order the applications are received.

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LAST NAME | FIRST NAME | DATE OF BIRTH (MO / DAY / YEAR) | GRADE COMPLETED

MAILING ADDRESS | HOME PHONE NUMBER + AREA CODE

CITY | STATE | ZIP CODE | DISTRICT | OUTPOST NUMBER

T-SHIRT INFORMATION: (ADULT SIZES ONLY) Check one: ☐ M ☐ L ☐ XL ☐ XXL

### Requirements for attendance

⇒ Current Adventure Ranger or Expedition Ranger member
⇒ Completed application with all required signatures and camp fee
⇒ Be recommended by your commander

I RECOMMEND THIS APPLICANT PARTICIPATE IN THE EAGLE ROCK ADVENTURE CAMP.

COMMANDER'S SIGNATURE _____ DATE _____

**METHOD OF PAYMENT** The registration can be paid by an adult with check or credit card.
☐CHECK ENCLOSED Make payable to**: Royal Rangers** (include current address and driver's license number.)
☐CREDIT CARD If paying via credit card include the following information: ☐VISA ☐MC ☐Discover Card

Registration Fee **$200.00**

CARD HOLDER'S NAME (PRINT) _____ CARD HOLDER'S ADDRESS _____

CREDIT CARD NUMBER

CARD HOLDER'S PHONE # ( _____ ) _____

EXP. DATE (MO / YR)

CARD HOLDER'S SIGNATURE _____

List other campers being paid for by this charge. (PLEASE PRINT)

Please complete this form and the medical information data and send with payment to the national Royal Rangers ministries:

Royal Rangers
1445 N. Boonville Ave.
Springfield, MO 65802-1894

**All applications must be received two weeks before camp start date.**

# Medical Record

*A Sports physical examination by a health practitioner with his/her signature is required for participation at camp.*

Applicants Name _____ Examination Date ____/____/____ Height _____ Weight _____

**Health History**

To be completed by the health practitioner. Has the applicant experienced the following?

Check either "Yes" or "No."

If "Yes" explain under "remarks and Medical Facts we should know."

| | | | | |
|---|---|---|---|---|
| Sinus condition | ☐ Yes | ☐ No | Any medical care in past year? | ☐ Yes ☐ No |
| Ear problem | ☐ Yes | ☐ No | | |
| Lung problem | ☐ Yes | ☐ No | Any surgery within past year? | ☐ Yes ☐ No |
| Heart trouble | ☐ Yes | ☐ No | | |
| High blood pressure | ☐ Yes | ☐ No | Exposed to infectious: | |
| Allergy-Asthma | ☐ Yes | ☐ No | | |
| Fainting or dizzy spells | ☐ Yes | ☐ No | Disease past 3 weeks | ☐ Yes ☐ No |
| Diabetes | ☐ Yes | ☐ No | Hepatitis past 6 months | ☐ Yes ☐ No |
| Appendix removed | ☐ Yes | ☐ No | Any disorder preventing strenuous activity? | ☐ Yes ☐ No |
| Shortness of breath | ☐ Yes | ☐ No | | |
| Skin infection | ☐ Yes | ☐ No | Taking prescription medicine of any type? | ☐ Yes ☐ No |
| Hearing difficultly | ☐ Yes | ☐ No | | |
| Bad eyesight | ☐ Yes | ☐ No | Any reaction of drugs or medicine of any type | ☐ Yes ☐ No |
| Wear contact lenses? | ☐ Yes | ☐ No | | |

Food or drug allergies _____

I am currently taking following medications_____

Remarks and Medical facts we should know: _____

_____

Health Practitioner's Name (Print) _____ Address _____

Health Practitioner's Signature: _____ City _____ State _____ Zip _____

Give latest date of inoculation or vaccination against following:

| | |
|---|---|
| Tetanus | ____/____/____ |
| Measles | ____/____/____ |
| Diphtheria | ____/____/____ |
| Polio | ____/____/____ |
| Typhoid | ____/____/____ |
| Small Pox | ____/____/____ |

## In case of emergency please notify:

LAST NAME _____ FIRST NAME _____ RELATIONSHIP _____

MAILING ADDRESS _____ STATE _____ ZIP CODE _____ DAYTIME CONTACT PHONE NUMBER ___-___-____

HEALTH INSURANCE COMPANY'S PHONE NUMBER ___-___-____ EVENING CONTACT PHONE NUMBER ___-___-____

HEALTH INSURANCE COMPANY'S NAME _____

POLICY NUMBER _____ CERTIFICATE NUMBER _____ EFFECTIVE DATE OF COVERAGE _____

**Parent/Legal Guardian Consent:** The signature of a parent or legal guardian is required for a minor to attend the Eagle rock Adventure Camp held at Camp Eagle Rock, MO, The parent's or legal guardian's signature below indicates: Permission to administer medical attention to the minor in the event of a medical emergency.

PRINT COMPLETE NAME OF MINOR _____ PARENT/LEGAL GUARDIAN SIGNATURE _____ DATE _____