

South Carolina Royal Rangers

Ranger Kids Overnighter

June 5-6, 2015, First Assembly, Sumter

Church Name:					Outpost #:	
Address:					*Chartered:	<input type="checkbox"/> YES <input type="checkbox"/> NO
City:		SC	Zip:		Phone:	() -
OP Coordinator:					Phone:	() -

**An outpost does not need to be chartered to attend the RKO. Non-chartered outposts will pay a higher registration fee.
If your outpost charter is not current and you would like to charter, please contact your district director.*

STAFF USE ONLY

Total number of Ranger Kids			
Total number of Male Leaders (do not include pastors)			
Total number of Female Leaders (do not include pastors)			
Total number of On-Staff Pastors			
Total number REGISTERED for Pow-Wow			

VOLUNTEERS DO NOT REGISTER WITH THEIR OUTPOST. VOLUNTEERS USE THE SEPARATE VOLUNTEER REGISTRATION FORM AVAILABLE ON-LINE. VOLUNTEERS AND ON-STAFF PASTORS ARE NO-CHARGE.

REGISTRATION – USE APPROPRIATE LINE(S)

			Total #	TOTAL DUE
CHARTERED OUTPOST - \$12/person if post marked on or before May 23, 2015	\$12	x		\$
NON-CHARTERED OUTPOST - \$15/person if post marked on or before May 23, 2015	\$15	x		\$
CHARTERED OUTPOST - \$16/person if post marked after May 23, 2015	\$16	x		\$
NON-CHARTERED OUTPOST - \$20/person if post marked after May 23, 2015	\$20	x		\$
SUBTRACT APPROPRIATE AMOUNT FOR ON-STAFF PASTOR(S)		-		\$
TOTAL AMOUNT DUE →				\$

Please return this application with payment payable to SC Royal Rangers to:

SC District Royal Rangers
RKO Registration
417 Hermitage Court
Lexington, SC 29072-8083

REFUND POLICY: No refunds will be made. Any outpost submitting funds greater than attendance will receive a credit toward the next district event or to a SCRR Store order, less \$5.00/person. Any credit must be used by December 31 of the same calendar year or it will be considered a donation.

MEDICAL FORMS: ALL persons attending RKO must have a current SCRR medical form. The commanders' and Rangers' forms dated APRIL 2012 must be used. This form is available on the web site – www.scdrr.org/forms.htm. Please remind your Ranger parents and all leaders this form MUST BE NOTARIZED WITH SEAL! Your cooperation is appreciated.

PASTOR'S AUTHORIZATION OF ADULT WORKERS. This form is available on the web site. A staff pastor must initial beside the name of each adult and then sign the bottom of the form. This form is mandatory and is for the protection of our Rangers. **DO NOT MAIL** this form with your registration. Bring it with you to the event.

OP Coordinator Signature _____

DATE: _____

South Carolina District Royal Rangers

Pastor's Authorization of Adult Workers for RR Events

(Please type or print)

Church Name: _____ Outpost #: _____

Pastor: _____ Phone: () - _____

SCRR Event: _____ Event Date: _____

Dear Pastor,

Any adult age 18 or older who will attend a South Carolina District Royal Rangers (SCDRR) event must be approved by the **senior pastor or other on-staff pastor** overseeing the Royal Rangers outpost from your church. Please list all adults on the lines below and initial each beside each person's name, then sign the form. ***This form must be presented with the outpost when they arrive at the event. DO NOT MAIL with the outpost registration.*** The purpose of this form is to ensure the safety of our boys and qualify the men and women you would have attend a Royal Rangers event. Qualifications for adults attending a SCDRR event are as follows:

- He/she is a Born-Again Christian and well grounded in the Word of God.
- He/she is loyal to the church.
- His/her habits and ideals are above reproach.
- He/she likes and enjoys working with boys.
- He/she has a consistent testimony in daily Christian Living.
- He/she is able to lead and delegate authority.
- He/she possesses good judgment.
- He/she is willing to accept responsibility
- He/she has earned the respect of others by his/her actions and words.

RK—Ranger Kids Commander
 DR—Discovery Commander
 AR—Adventure Commander
 ER—Expedition Commander
 OC—Outpost Coordinator
 LT—Lt. Commander
 OT—Other, please specify

Pastor's Initials for EACH person	Adult's Name <small>(Please type or print)</small>	Position in Outpost <small>(RK, DR, AR, ER, OC, LT, OT)</small>

All adults attending a SCDRR event agree to be responsible for their Royal Rangers and the activities of their outpost, conduct themselves in accordance to the Royal Ranger Code, carry out the assignments they have volunteered for, provide for the safety of their outpost, follow the rules and guidelines for the event, and understand that breaking event rules may be cause for dismissal from participating in the event (this applies to both boys and leaders).

My signature certifies that I have approved the above list of adults to attend the event named as a qualified member or volunteer of my church's RR Outpost and they pose no threat to the safety or wellbeing of the boys who attend this event.

Pastor's Signature: _____ **Date:** _____

THIS FORM FOR ADULT LEADERS AGE 18 AND UP ONLY
SOUTH CAROLINA DISTRICT ROYAL RANGERS
EMERGENCY MEDICAL INFORMATION AND AUTHORIZATION
FOR ADULT LEADERS

(PLEASE TYPE OR PRINT. **ALL** INFORMATION IS REQUIRED. INCLUDE AREA CODE FOR ALL PHONE NUMBERS)

Name _____ Date of Birth _____
 Address _____
 City _____ State _____ Zip _____
 Home Phone () - _____ Work Phone () - _____ Cell Phone () - _____
 Family Doctor (FULL NAME) _____ Doctor's Phone () - _____
 Spouse or Nearest Relative _____ Phone () - _____
 OR Neighbor _____ Neighbor's Phone () - _____
 Insurance Provider _____ Insurance Co Phone () - _____
 Policy # _____ Certificate # _____ Effective Date of Coverage _____

In the event insurance is needed, your insurance will be primary and any insurance provided by the church or district Royal Rangers is secondary

CERTIFICATIONS – Indicate expiration date. Leave blank if not current or not applicable. (MM/yyyy)

Lifeguard Certification _____ CPR/AED Certification _____ 1st Aid Certification _____ None

Medical History

Sinus Condition <input type="checkbox"/> YES <input type="checkbox"/> NO	Heart trouble <input type="checkbox"/> YES <input type="checkbox"/> NO	Reaction to stinging or biting insects <input type="checkbox"/> YES <input type="checkbox"/> NO
Shortness of breath <input type="checkbox"/> YES <input type="checkbox"/> NO	High blood pressure <input type="checkbox"/> YES <input type="checkbox"/> NO	Fainting or dizzy spells <input type="checkbox"/> YES <input type="checkbox"/> NO
Ear problem <input type="checkbox"/> YES <input type="checkbox"/> NO	Blood Disorder <input type="checkbox"/> YES <input type="checkbox"/> NO	Seizures <input type="checkbox"/> YES <input type="checkbox"/> NO
Skin infection, rash, eczema <input type="checkbox"/> YES <input type="checkbox"/> NO	Bad eyesight <input type="checkbox"/> YES <input type="checkbox"/> NO	Diabetes <input type="checkbox"/> YES <input type="checkbox"/> NO
Lung problem <input type="checkbox"/> YES <input type="checkbox"/> NO	Wear contact lenses <input type="checkbox"/> YES <input type="checkbox"/> NO	Kidney disease <input type="checkbox"/> YES <input type="checkbox"/> NO
Hearing difficulty <input type="checkbox"/> YES <input type="checkbox"/> NO	Allergy, Pollen/environmental <input type="checkbox"/> YES <input type="checkbox"/> NO	Appendix removed <input type="checkbox"/> YES <input type="checkbox"/> NO
Had heat illness or exhaustion <input type="checkbox"/> YES <input type="checkbox"/> NO	Allergy, Food <input type="checkbox"/> YES <input type="checkbox"/> NO	Special diet required <input type="checkbox"/> YES <input type="checkbox"/> NO
	Asthma <input type="checkbox"/> YES <input type="checkbox"/> NO	

Taking prescription medicines, over-the-counter (OTC) medicines or inhalers <input type="checkbox"/> YES <input type="checkbox"/> NO	Any reaction to drugs or medicine of any type <input type="checkbox"/> YES <input type="checkbox"/> NO
Been restricted from strenuous activity, exercise or sports? <input type="checkbox"/> YES <input type="checkbox"/> NO	Diagnosed and/or treated for infectious disease past year <input type="checkbox"/> YES <input type="checkbox"/> NO
Have you ever had surgery? <input type="checkbox"/> YES <input type="checkbox"/> NO	Diagnosed with hepatitis <input type="checkbox"/> YES <input type="checkbox"/> NO
	Date of last tetanus shot _____

Please explain any "YES" you may have answered on the above section in the space provided below. For all current prescription and OTC medications include name of medication, doses and special instructions. Please be specific regarding strength, interval between doses, time of administration and special instructions/precautions. Use back of form as needed.

Information, Directions and Other Information

Signature _____ Date* _____
Please sign form ONLY in the presence of a Notary Public **This form is valid for one year from date of signature.*

Notary Public Signature _____

My commission expires _____

The seal is **required** by the SC District Royal Rangers

(Seal)

SOUTH CAROLINA DISTRICT ROYAL RANGERS ACTIVITY AUTHORIZATION / EMERGENCY MEDICAL INFORMATION AND AUTHORIZATION FOR RANGERS UNDER AGE 18

(PLEASE TYPE OR PRINT. **ALL** INFORMATION IS REQUIRED. INCLUDE AREA CODE FOR ALL PHONE NUMBERS)

Name _____		Date of Birth _____	
Parents: Father's Name _____	Mother's Name _____		
Address _____	City _____	State _____	Zip _____
Home Phone () - _____	Father's Work Phone () - _____	Father's Cell Phone () - _____	
	Mother's Work Phone () - _____	Mother's Cell Phone () - _____	
Family Doctor (FULL NAME) _____	Doctor's Phone () - _____		
Nearest Relative _____	Relative's Phone () - _____		
OR Neighbor _____	Neighbor's Phone () - _____		
Insurance Provider _____	Insurance Co Phone () - _____		
Policy # _____	Certificate # _____	Effective Date of Coverage _____	

In the event insurance is needed, your insurance will be primary and any insurance provided by the church or district Royal Rangers is secondary

Can your child swim? YES NO Beginner Intermediate Proficient Lifeguard

Medical Treatment Authorization

_____ has my permission to participate in any sanctioned activity of the _____ church (hereafter "the church") located at (address) _____ and/or the South Carolina District Royal Rangers provided he is properly supervised by authorized adult leaders. Such activities would include field trips, campouts, ball games, swimming (if allowed by parent), and any other normal scouting activity.

I understand that all necessary precautions have been taken for the safety of my child and that I will be notified in the case of an emergency or injury. I authorize the calling of a doctor and the providing of medical services/treatment in the case of an accident, injury or sickness, by a licensed health care provider, if for any reason I cannot be contacted or present. I understand that the church or the South Carolina District Royal Rangers will not take care of medical expenses incurred; they will be my responsibility as parent/guardian.

I agree to notify the church in the event of any health changes that would restrict my child's participation in any of the normal activities of the group. I also understand that the commander reserves the right to restrict my child from any activity that he does not feel is within the physical capabilities of my child.

Signature of parent/guardian _____ Date* _____
*Please sign this form **only** in the presence of a Notary Public* **This form is valid for one year from date of signature.*

Notary Public Signature _____

My commission expires _____

The seal is **required** by the SC District Royal Rangers **(Seal)**

Please complete the opposite side of this form.

Medical History

Boy's Name _____ Date of Birth _____ Weight _____ lbs.

Sinus Condition	<input type="checkbox"/> YES <input type="checkbox"/> NO	Heart trouble	<input type="checkbox"/> YES <input type="checkbox"/> NO	Reaction to stinging	
Shortness of breath	<input type="checkbox"/> YES <input type="checkbox"/> NO	High blood pressure	<input type="checkbox"/> YES <input type="checkbox"/> NO	or biting insects	<input type="checkbox"/> YES <input type="checkbox"/> NO
Ear problem	<input type="checkbox"/> YES <input type="checkbox"/> NO	Blood Disorder	<input type="checkbox"/> YES <input type="checkbox"/> NO	Fainting or dizzy spells	<input type="checkbox"/> YES <input type="checkbox"/> NO
Skin infection, rash,		Bad eyesight	<input type="checkbox"/> YES <input type="checkbox"/> NO	Seizures	<input type="checkbox"/> YES <input type="checkbox"/> NO
eczema	<input type="checkbox"/> YES <input type="checkbox"/> NO	Wear contact lenses	<input type="checkbox"/> YES <input type="checkbox"/> NO	Diabetes	<input type="checkbox"/> YES <input type="checkbox"/> NO
Lung problem	<input type="checkbox"/> YES <input type="checkbox"/> NO	Allergy:		Kidney disease	<input type="checkbox"/> YES <input type="checkbox"/> NO
Hearing difficulty	<input type="checkbox"/> YES <input type="checkbox"/> NO	Pollen/environmental	<input type="checkbox"/> YES <input type="checkbox"/> NO	Appendix removed	<input type="checkbox"/> YES <input type="checkbox"/> NO
Had heat illness or		Allergy, Food	<input type="checkbox"/> YES <input type="checkbox"/> NO	Special diet required	<input type="checkbox"/> YES <input type="checkbox"/> NO
exhaustion	<input type="checkbox"/> YES <input type="checkbox"/> NO	Asthma	<input type="checkbox"/> YES <input type="checkbox"/> NO		

Taking prescription medicines, over-the-counter (OTC)		Any reaction to drugs or medicine of any type	<input type="checkbox"/> YES <input type="checkbox"/> NO
medicines or inhalers	<input type="checkbox"/> YES <input type="checkbox"/> NO	Diagnosed and/or treated for infectious disease	
Been restricted from strenuous activity, exercise		past year	<input type="checkbox"/> YES <input type="checkbox"/> NO
or sports?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Diagnosed with hepatitis	<input type="checkbox"/> YES <input type="checkbox"/> NO
Have you ever had surgery?	<input type="checkbox"/> YES <input type="checkbox"/> NO	Date of last tetanus shot	_____

Please explain any "YES" you may have answered on the above section in the space provided below. For all current prescription and OTC medications include name of medication, doses and special instructions. Please be specific regarding strength of medication (milligrams), route of administration (oral, inhaled, nasally, etc), how often given, what time of day to give, when to give (as needed for...), storage requirements and special instructions/precautions. The medication and instructions should be given to his commander.

Basic first aid will be administered to your child as needed. In addition, some OTC medications may be administered to your child with your permission. These medications will be available through a registered or licensed practical nurse, or a commander, should the need arise.

Do you give permission to have OTC medication administered to your child? _____ YES NO

If "YES" do you want to be notified in the event your child has been given OTC medication? _____ YES NO

Please note below any OTC medication you DO NOT want your child to receive.

Information, Directions and Other Information

Please provide any other information you believe we may need for the proper treatment of your child, should the need arise.