YOUNGSTOWN WARREN AREA
INDIVIDUAL REGISTRATION FORM

Date: _____

This entire page MUST be completely filled out, turned in to your Senior Commander, and brought to the Section Royal Ranger Event.

PLEASE PRINT OR TYPE

BOY'S NAME_____ AGE _____OUTPOST_____

ADDRESS _____

CITY _____STATE _____ ZIP _____

HOME PHONE (_____) _____ CELL PHONE (_____) _____

CHURCH _____ CITY_____

PASTOR _____ COMMANDER RESPONSIBLE _____

PARENT PERMISSION FORM

I hereby authorize _____ to accompany the Royal Rangers to the _____
I understand the arrangements and feel that adequate precautions for the safety of my child have been, and will continue to be, taken. I will not hold the local church or its leaders; or the Area Staff; or the Network Staff; or the Ohio District Council, Inc of the Assemblies of God; responsible for any accidents. I understand the Section will provide an emergency First Aid station on location.

SIGNATURE _____ DATE _____

EMERGENCY MEDICAL INFORMATION

This form must be signed by a parent or guardian, and accompany the child to the event. The purpose of the form is to make it possible for parents and guardians to authorize the provisions of emergency treatment for MINOR Royal Rangers who may become ill or injured at a Section event. You can authorize such emergency treatment for your child, by completing this form.

I, _____ OF _____ THE _____
(Parent or guardian's name) (City), (State) (Father, Mother; Guardian)

OF _____, A MINOR.
(Name of child)

WHO IS ATTENDING A ROYAL RANGERS' SECTION EVENT, DO HEREBY GIVE A MINOR. WHO IS ATTENDING A ROYAL RANGERS' SECTION EVENT, DO HEREBY GIVE MY CONSENT, IN THE EVENT THE ADMINISTRATION OF ANY TREATMENT DEEMED NECESSARY BY LICENSED PHYSICIANS, DENTISTS, OR EMERGENCY PERSONNEL SERVING THE YOUNGSTOWN WARREN SECTION AT SAID EVENT

(SIGNED) _____ DATE _____
(Parent or guardian's Signature)

Doctor's Name _____ Phone_____

CHILD'S MEDICAL HISTORY:

Is he in good health? ☐ Yes ☐ No If NO, please explain. _____

Any food, medication, or other allergies? _____

Physical Impairments (Heart, Epilepsy, etc.): _____

Specify any medication that must be administered: _____

Date of last Tetanus shot: _____

FOR ANY SPECIAL INSTRUCTION PLEASE USE THE OTHER SIDE IF NECESSARY