

FOR OFFICE USE
REC: _____
DUE: _____
SNT: _____

2004 NATIONAL TRAINING CAMP APPLICATION



PLEASE PRINT

PERSONAL GPH ACCOUNT NO. _____

NAME _____

ADDRESS _____

CITY, STATE, ZIP _____

HOME PHONE (____) _____

EMAIL _____

OCCUPATION _____

DISTRICT _____ OUTPOST # _____ DATE OF BIRTH _____

IN CASE OF EMERGENCY, PLEASE NOTIFY

NAME _____

ADDRESS _____

CITY, STATE, ZIP _____

PHONE (____) _____

RELATIONSHIP _____

SPOUSE'S NAME _____

APPLICANT'S RR POSITION _____

PASTOR'S SIGNATURE _____ DATE _____

NATIONAL TRAINING CAMP

01 [] FLORIDA	FORT MEADE	(CAMP WILDERNESS)	JAN. 29-FEB. 1
02 [] MINNESOTA	PILLAGER	(LAKE PLACID)	MAY 6-9
03 [] CALIFORNIA	MINERAL	(MT. LASSEN CAMP)	MAY 13-16
04 [] OHIO	MARENGO	(HEARTLAND CONF. RETREAT CNTR.)	MAY 20-23
05 [] HAWAII			AUGUST 5-8
06 [] MISSOURI	EAGLE ROCK	(CAMP EAGLE ROCK)	SEPTEMBER 2-5
07 [] CALIFORNIA	TWIN PEAKS	(PINE CREST CHR. CONF. CENTER)	SEPTEMBER 9-12
08 [] NEW JERSEY	WOODSTOWN	(CAMP ROOSEVELT)	SEPTEMBER 9-12
09 [] WASHINGTON	MEDICAL LAKE	(SILVER LAKE CAMP)	SEPTEMBER 23-26
10 [] OKLAHOMA	CHANDLER	(RANGERLAND)	OCTOBER 7-10
11 [] TEXAS	SAN ANTONIO	(LATIN AMERICAN BIBLE INST – LABI)	OCTOBER 21-24
12 [] PUERTO RICO	ARECIBO	(CAMP ASAMBLEA DE DIOS)	NOVEMBER 18-21
13 [] FLORIDA	FORT MEADE	(CAMP WILDERNESS)	JANUARY 27-30, 2005

You must be **male, 18 years or older, and in good health** in order to participate in the strenuous activities of the training camp. Therefore, you **must** have a physical examination. ****A MEDICAL RECORD FORM OF THE EXAM MUST ACCOMPANY THIS APPLICATION****. After examination, please sign the following statement: **"After consulting with my physician, I know of no physical limitation that would restrict me from participating in the camp activities."**

SIGNATURE _____ DATE _____

Any medical facts we should know: _____

REGISTRATION FEES

Because of the limited size and the advanced cost of setting up these camps, a **\$50** preregistration fee must accompany this application. This will be applied toward the total camp fee of **\$175**. You will receive a **\$25 discount** if you preregister no later than **4 weeks** prior to the camp start date. Please submit your application as early as possible. **Low enrollment of these camps will be determined at 4 weeks prior camp start date. At such time these camps will be cancelled with a total refund.** Should you need to cancel you must notify the National RR office no later than **4 weeks** prior to camp start date. Your preregistration fee or total camp fee if paid in advance, will be refunded **minus a \$20** administration fee. Cancellation after this date is nonrefundable! Should you choose, your fees may be applied toward another camp of your choice. Postmark will determine such dates. A map and additional information will be sent after your registration is approved by the National RR Ministries office.

WALK-INS will not be authorized/permitted unless permission is granted by the National RR Ministries office.

MAIL THIS FORM TO: Royal Rangers, 1445 N. Boonville Avenue, Springfield, MO 65802-1894

MEDICAL RECORD NATIONAL ROYAL RANGER TRAINING CAMPS

GENERAL INFORMATION

A physical examination by a physician is required for enrollment in a national training camp. Persons arriving at a camp without having had a physical examination will be required to have such an examination at personal expense by a local physician. This form is to be completed and mailed in with the application, or brought with you to the camp. The National Royal Rangers Ministries office has the prerogative to accept or reject any person based upon his medical health.

HEALTH HISTORY	To be completed by the applicant and/or the physician. Answer YES or NO to the following and briefly explain all yes answers under "REMARKS."				
Sinus Condition		Shortness of Breath		Exposed to Infections	
Ear Problem		Skin Infection		A) Disease Past Three Weeks	
Lung Problem		Hearing Difficulty		B) Hepatitis Past Six Months	
High Blood Pressure		Bad Eyesight		Any disorder Preventing	
Allergy - Asthma		Do you wear contacts		Strenuous Activities	
Fainting or Dizzy Spells		Any Medical Care		Taking Prescription Medicine	
		Within the Past Year		Any Reaction to Drugs or	
		Any Surgery Within Past Year		Medication of Any Type	

REMARKS AND MEDICAL FACTS WE SHOULD KNOW IN CASE OF EMERGENCY:

Give Latest Date of Inoculation or Vaccination Against the Following	Tetanus	Small Pox	Measles	Typhoid	Diphtheria	Polio
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I know of no physical reason that would restrict me from participation in camp activities.

Signature _____ Date _____

PHYSICAL EXAMINATION

Physician Please Note: Trainees enrolled in outdoor activities are exposed to strenuous physical activity. Therefore, the applicant must be physically sound and strong enough to engage in such activity.

Print Applicant's Name:	Examination Date	Birth Date	Height	Weight	Occupation
BRIEFLY INDICATE CONDITION	HEART	LUNGS	THROAT	EARS	
	EYES	SKIN	HERNIA	BLOOD PRESSURE	

In your opinion, is the applicant physically capable to take training? YES _____ NO _____

REMARKS:

Physician's Name	Physician's Signature
Physician's Address	Physician's Business Phone Number with Area Code