Southern Missouri District Royal Rangers

BACKPACKING ACTION & ADVENTURE KAMPS

Trainee Application

Name: _____ Date of Birth: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Church Name & City: _____ Outpost #: _____

Which camp will you be attending? *(mark one)*

☐ **BAC - Backpacking ACTION Camp**: Must be a graduate of the 8th grade. Includes BAC patch, camp & class materials, lunch on Thursday, and transportation to & from the trail head.....$25.00

☐ **BAK - Backpacking ADVENTURE Kamp**: Must be a graduate of the 5th grade. Includes lunch on Thursday & transportation to & from the trail head. Adult male leaders may attend as well. $10.00

T-shirt size *(adult sizes only – circle one)*: S M L XL 2XL 3XL

Hat size (if known): _____ Last grade in school completed (boys only): _____

- Camp Details for 2025 -

Camp Date:	June 19-21, 2025
Location:	Meet at Ozark AG at 10AM. Hike will take place along the Buffalo River (Arkansas).
Registration Fee:	See above. Full fees must accompany this application.
Application Deadline:	June 15th (Sunday)
Mail this application to:	SoMo District Royal Rangers, 528 W Battlefield, Springfield MO 65807
Contact:	Mark Jones at (417) 343-0463 or markjonesranger@hotmail.com
Equipment & Meals:	Please refer to the BAC / BAK handout at "SoMoRangers.com/BAC" for details

All trainees must pre-register before the application deadline shown above. Please make checks payable to "SoMo *District Royal Rangers.*" All participants are responsible for their own food and gear. Recommended food and gear as well as additional details can be found on the **SoMo District Backpacking Handout** on the website at "SoMoRangers.com/BAC." A **Health History & Medical Authorization** form is also required.

APPROVAL SIGNATURES: *All boys must be approved by their parents and Outpost Coordinator to participate in the camp. All adults (18 yrs of age) must also be approved by their Outpost Coordinator and church to work with boys, which must include a criminal & child abuse background check. Signatures to the right represent these approvals.*

_____
Parent's Signature (for minors)

_____
Outpost Coordinator's Signature (boys & adults)

_____
Pastor's Signature (adults only)

Revised 3/27/25

Backpacking Action & Adventure Camps

HEALTH HISTORY & MEDICAL AUTHORIZATION FORM

Name: _____ Church Name & City: _____

To be completed by the applicant and/or physician. Please check all boxes that apply and briefly explain all checked boxes under remarks:

	Lung or breathing problems		Hearing or ear problems		Skin infections
	Allergies		Eye or vision problems		High blood pressure
	Asthma		Sinus or nasal problems		Fainting or dizziness

Are you taking any prescription medications of any kind? If so, please list medication and purpose: _____

_____

_____

_____

Are you allergic to any kind of drugs or medications? If so, please specify: _____

_____

_____

Are you aware of any medical condition that may prevent or limit your involvement in strenuous physical activities? If so, please specify: _____

_____

_____

_____

Remarks and additional notes. Use additional sheets if needed.

_____

_____

_____

Give latest date of inoculation or vaccination against the following:

Tetnus		Typhoid	
Small Pox		Diphtheria	
Measels		Polio	

In the event that hospitalization is needed, please complete the following:

Name of Insured (Policy Holder): _____

Medical/Hospital Insurance Company _____

Policy or certificate number _____

Employer _____ Employers group number _____

PLEASE NOTE: Participation in this event is voluntary and requires the ability to walk several miles unassisted along rough and uneven trails, up and down embankments, and across moving streams potentially several feet deep, carrying a backpack of 30 lbs. or more (depending on the gear you bring). Each individual will be personally responsible for their own emergency or medical care and evacuation should it become necessary.

MEDICAL AUTHORIZATION: In case of emergency, I hereby give permission to the physician or medical personnel at hand to render treatment at his/her discretion. Should it be deemed necessary by a qualified physician, I authorize hospitalization, anesthesia, surgery, or injection of medication.

_____ _____

Parents/Guardian (for minors) or Participant Signature Date