

# FCF FALL TRACE

October 10, 2025

Camp Kerby

3039 Jericho Rd

LaGrange, KY 40031



Register Online

FALL TRACE REGISTRATION

October 10-12, 2025

Camp Kerby, LaGrange KY

Indicate the numbers attending

- FCF Old Timer (18+ older)
- FCF Young Buck (under 18)
- FCF Guest (18+ older)
- FCF Guest (under 18)

**Old Timers = \$35.00 each**

**Young Buck = \$30.00 each**

**Guest Old Timers = \$20.00 each**

**Guest Young Buck = \$15.00 each**

**\*No exceptions**

**Personal Information (Please print Clearly)**

\_\_\_\_\_  
Last Name                      Middle Initial                      First Name

\_\_\_\_\_  
Mailing Address (Street or F.F.D.)

\_\_\_\_\_  
City    State                      Zip code

\_\_\_\_\_  
Email Address

FCF     Frontiersmen     Buckskin     Wilderness

Guest Of: \_\_\_\_\_

- FCF Young Buck (under 18)
- FCF Old Timer (18+ older)
- FCF Guest (under 18)
- FCF Guest (18+ older)

\_\_\_\_\_  
Area Code Home Phone

\_\_\_\_\_  
Area Code Work Phone

\_\_\_\_\_  
Area Code Cell #

**Church Information**

\_\_\_\_\_  
Church Name

\_\_\_\_\_  
Church Address

\_\_\_\_\_  
City    State    Zip Code

\_\_\_\_\_  
Email Address

\_\_\_\_\_  
District (Abbreviate)                      Outpost

\_\_\_\_\_  
Area Code Church Phone

\_\_\_\_\_  
Area Code Church Fax

**Craft & Project:**

**We will be offering those who wish to make a craft/project the opportunity the materials will be furnished and the cost will be \$10.00 Please indicate the number that will participate by October 1**

**Number of crafts = \_\_\_\_\_ X \$10.00 = \_\_\_\_\_ For information on the craft contact Mike Snyder**

**Method of payment: Payment must accompany all applications for registration to be processed.**

**Check Enclosed: Checks must be written to Kentucky District FCF Royal Rangers**

**Mail To: Mike Snyder 2415 Cherry Creek Rd. LaGrange, Ky. 40031**

**GRAND TOTAL**

\$

**Online Registration is available at:**

**Personal Medical Record**

**Insurance Information**

Applicant's Full Name

Health Insurance Company's Name

**In case of emergency please notify:**

Last Name *(please print)*

First Name

Policy Number

Certificate Number

Daytime Contact Phone Number

Evening Contact Phone Number

Effective date of coverage

Health Insurance Company's Phone Number

**General Information:**

*A Personal Medical Record must be completed by each applicant for participation. Records for minors (under age 18) must include a parent or guardian's signature. Royal Rangers office reserves the right to accept or reject any person based upon his medical health.*

**Health History** To be completed by the applicant (if over 18) or by a parent/guardian if the applicant is a minor (under age 18). Has the applicant experienced the following? Check "Yes" or "No."

Sinus condition	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	Shortness of breath	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	Exposed to infectious:				
Ear problem	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	Skin infection	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	Disease past 3 weeks	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Lung problem	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	Hearing difficulty	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	Hepatitis past 6 months	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Heart trouble	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	Bad eyesight	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	Any disorder preventing strenuous activity?	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
High blood	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	Wear contact lenses	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	Taking prescription medicine?	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Allergy-Asthma	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	Any medical care in the past year?	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	Any reaction to drugs or medicine or any type?	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Fainting or dizzy	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	Any surgery within past year?	<input type="checkbox"/>	yes	<input type="checkbox"/>	no	Special diet required?	<input type="checkbox"/>	yes	<input type="checkbox"/>	no
Diabetes	<input type="checkbox"/>	yes	<input type="checkbox"/>	no										
Appendix	<input type="checkbox"/>	yes	<input type="checkbox"/>	no										

Food or drug allergies \_\_\_\_\_  
 I am currently taking the following medications \_\_\_\_\_  
 Remarks and medical facts: \_\_\_\_\_

Special dietary \_\_\_\_\_  
 Additional remarks \_\_\_\_\_

Give latest date of inoculation or vaccination against following:

	Date		Date
Tetanus		Small Pox	
Measles		Typhoid	
Diphtheria		Polio	

  

Birth Date	Height	Weight

Parent/Guardian's Name (Please Print) \_\_\_\_\_  
 ( ) \_\_\_\_\_  
 Parent/Guardian's Area Code and Phone Number \_\_\_\_\_

Parent / Guardian's Address \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Required Release Signatures

**Parent/Legal Guardian Consent & Model Release** *(Required for all applicants under 18 years of age)* I, the undersigned, as parent or legal guardian of the above named minor do hereby consent to his participation in this event and authorize the use of emergency medical care at the discretion of the adult event leadership. I further acknowledge my understanding that media footage, including audio, video and photos, may be recorded at this event for future promotional use and hereby consent to the use of such items containing images of my child in any form and relinquish all rights of ownership or compensation. It is further understood that acceptance of these terms is a condition of my child's participation in this event.

Print Complete Name of Minor \_\_\_\_\_ ✕ Parent/Legal Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

**Pastor's Certification** *(Required for all applicants 18 years of age or older)* I, the undersigned, as Pastor of the above named adult participant do hereby acknowledge that the individual has been properly screened and approved for children or youth work in our church and provide my unqualified endorsement to his/her participation in this event.

✕ \_\_\_\_\_ Date \_\_\_\_\_  
 Pastor's Signature

**Applicant's Signature** *(Required for all applicants)* I, the undersigned, hereby acknowledge that to the best of my knowledge, I qualify for participation in this event and do hereby agree to abide by the rules and standards established for this event by its appointed leadership. I acknowledge that the information provided on my Personal Medical Record is true and correct and I consent to the administration of emergency medical treatment at the discretion of the event leadership. I further acknowledge my understanding that media footage, including audio, video and photos, may be recorded at the event for future promotional use and hereby consent to the use of such items containing images of me in any form and relinquish all rights of ownership or compensation.

✕ \_\_\_\_\_ Date \_\_\_\_\_  
 Applicant Signature

# Frontiersmen Camping Fellowship

## Knife and Black Powder

### Permission Form

I am the parent or guardian of \_\_\_\_\_ who is a member of the Royal Rangers Program. I give, him permission to sell, trade, give, receive, or barter and have in his possession during any FCF event, any knife or black powder firearm as in appropriate for this type of historical reenactment activity.

Pleas consider this document as written consent for my son  
To participate in any of the Frontiersmen Camping Fellowship activities, which include black powder loading and shooting, knife and hawk throwing, flint and steel – fire starting, frontiersmen craft and workshop classes, and any other activities conducted.

\_\_\_\_\_  
Signature of parent or guardian Date

If you do not want your son, \_\_\_\_\_ participating in any of the above activities please list: \_\_\_\_\_

\_\_\_\_\_  
Signature of parent or guardian Date

If you are under the age of 18, you must have this form signed by your parent or guardian in order to participate in the above-mentioned activities at any FCF function.

Parents please complete:

Name of minor \_\_\_\_\_

Name of Parent completing form: \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Home phone and work phone: Home \_\_\_\_\_ Work \_\_\_\_\_

Age \_\_\_\_\_ Birth date of minor \_\_\_\_\_

Any information we should know about: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_