Full Gospel Church of Island Park
Royal Rangers Registration Form

Instructions: Please complete a copy of this form for each individual registering.

RANGER'S INFORMATION:

Full Name _____ Birthday ___/___/___ Grade _____

Nickname _____

Address _____

City,St,Zip _____

Phone Numbers ( ) ____ - _____ ( ) ____ - _____

Home Church _____

Personal Contact Info

Personal Phone ( ) ____-_____

Personal Email _____

Work Phone ( ) ____-_____

Work Email _____

Father/Guardian _____ Employer _____ Work Phone ( ) ____-_____

Email _____ Cell Phone ( ) ____-_____

Mother/Guardian _____ Employer _____ Work Phone ( ) ____-_____

Email _____ Cell Phone ( ) ____-_____

1) Emergency Contact _____ Relation _____ Phone ( ) ____-_____

2) Emergency Contact _____ Relation _____ Phone ( ) ____-_____

Full Gospel Church of Island Park
Royal Rangers Medical Form

All information on this form is Private & shall remain Confidential

HEALTH HISTORY

Check either Yes or No. If Yes is checked please explain under "Remarks and Medical Facts".

Sinus Condition	○ YES	○ NO	Shortness of Breath	○ YES	○ NO	Exposed to Infections:	
Ear Problem	○ YES	○ NO	Skin Infection	○ YES	○ NO	Disease past 3 weeks	○ YES ○ NO
Lung Problem	○ YES	○ NO	Hearing Difficulty	○ YES	○ NO	Hepatitis past 6 months	○ YES ○ NO
Heart Trouble	○ YES	○ NO	Bad Eyesight	○ YES	○ NO	Any disorder preventing strenuous activity?	○ YES ○ NO
High Blood Pressure	○ YES	○ NO	Wear Eye Glasses	○ YES	○ NO	Taking prescription medicine?	○ YES ○ NO
Allergy-Asthma	○ YES	○ NO	Wear Contact Lenses	○ YES	○ NO	Any Reaction to drugs or medicine of any type?	○ YES ○ NO
Fainting or Dizzy Spells	○ YES	○ NO	Any Medical Care within Past Year?	○ YES	○ NO	Get nervous or upset easily? Homesick?	○ YES ○ NO
Diabetes	○ YES	○ NO	Any Surgeries within Past Year?	○ YES	○ NO	Sleep Walker?	○ YES ○ NO
Appendix Removed	○ YES	○ NO	Special Diet Required?	○ YES	○ NO		
Dental Appliances	○ YES	○ NO					

Drug Allergies: _____

Current Medications: _____

Plant, Insect or Animal Allergies: _____

Remarks and Medical Facts: _____

_____

_____

Food Allergies or Special Diet: _____

_____

_____

Last Tetanus Shot ___/___/___

Swimming Level (Please Circle):
Non Swimmer, Beginner, Intermediate, Advanced

Doctor and Insurance Info

_____ ( ) ____-_____
Doctor's Name & Phone

_____ ( ) ____-_____
Insurance Company & Phone

_____
Policy ID# and Group Number

_____
Subscriber's Name & Relationship