

Please print clearly. This form may be copied. Use a separate form for each camper.
Health information on this form is gathered to assist us in identifying appropriate care.

The Naming Project Camp—Health Form Registration

**RETURN TO: Ross Murray, Naming Project Program Director,
328 8th Avenue #345, New York, NY 10001**

Camper Name _____
Address _____
City/State/Zip _____
Phone _____ Birthdate _____
Grade completed _____ Gender _____
Church _____
City _____
Amount paid by your church _____

Parent/Guardian _____
Work phone _____
E-mail Address _____
Siblings attending camp _____
Second parent or guardian _____
Phone _____ Work phone _____
Emergency Contact _____
Phone _____

Health History

(Give dates if yes)

____ Frequent Ear Infections
____ Heart Defect/Disease
____ Convulsions
____ Diabetes
____ Bleeding/Clotting Disorders
____ Hypertension
____ Mononucleosis Diseases
____ Chicken Pox
____ Measles
____ German Measles
____ Mumps

Immunizations

(give approx. dates)

____ DPT Permanent Shots (3)
____ Tuberculin
____ Polio Immunization
____ MMR (Measles, Mumps, Rubella)
____ Tetanus Toxioid Booster

Swimming Ability

____ Non-swimmer
____ Beginner-minimal skills;
avoids deep water
____ Intermediate-comfortable
in deep water
____ Advanced-extremely
comfortable, lifeguard

Allergies *(Dates not needed)*

____ Hay Fever
____ Poison Ivy, etc.
____ Insect Stings
____ Penicillin
____ Other Drugs _____
____ Asthma
____ Other _____

If born female, has this person menstruated? ____
If not, has it been discussed? ____
If so, is menstrual history normal? ____
Special Consideration _____

Chronic or recurring illness or medical condition that may affect Camp life

Dietary Restrictions _____
Emotional/Psychological/Spiritual conditions (fear, anxieties, etc.)

Medications (please list and send with your camper, please include
Instructions) _____

May acetaminophen/ibuprofen be administered if needed? Yes / No

Insurance Company _____ Policy# _____ Family Doctor _____
Phone _____ **Please send a copy of your card with this form.**

My child has permission to participate in all aspects of the program at The Naming Project, except as noted. I hereby give my permission to the physician selected by the camp to secure proper treatment, to hospitalize, to order injection, anesthesia, x-ray or surgery for my child as named above. The Naming Project will make every effort to contact me if my child needs emergency medical-surgical treatment. I understand that my insurance has primary coverage, and The Naming Project insurance is secondary.

Parent or Guardian Signature _____
Date _____