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

Allergies (*Dates not needed*)
___Hay Fever
___Poison Ivy, etc.
___Insect Stings
___Penicillin
___Other Drugs _____
___Asthma
___Other _____

Immunizations
(give approx. dates)
___DPT Permanent Shots (3)
___Tuberculin
___Polio Immunization
___MMR (Measles, Mumps, Rubella)
___Tetanus Toxiod Booster

Swimming Ability
____Non-swimmer
____Beginner-minimal skills; avoids deep water
____Intermediate-comfortable in deep water
____Advanced-extremely comfortable, lifeguard

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 _____