

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, Director, 888c 8th Avenue #523, New York, NY 10019

Camper Name _____
 Address _____
 City/State/Zip _____
 Phone _____ Birthdate _____
 Grade completed _____ Gender _____

Parent/Guardian _____
 Phone _____ E-mail Address _____
 Second parent or guardian _____
 Phone _____ E-mail Address _____
 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 Toxioid Booster

Swimming Ability

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

Has the camper menstruated? Yes _____ No _____ N/A _____
 If yes, has it been discussed? _____
 If no, is menstrual history normal? _____
 Special Consideration _____

Chronic medical condition that may affect camp life: _____

Dietary Restrictions _____

Emotional/Psychological/Spiritual conditions _____

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

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

Insurance Company _____ Policy# _____

Please send a copy of your card with this form

Family Doctor _____ Phone _____

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** _____