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,
2751 Hennepin Ave S, Suite #238, Minneapolis, MN 55408

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 Toxiod Booster

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

Female: Has this person menstruated? ____
If not, has it been discussed? ______
If so, is her menstrual history normal? _____
Special Consideration ___________________

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

Chronic or recurring illness or medical condition that may affect Camp life
____
Dietary Restrictions _______________________________________
Other suggestions that may help make your child's week more Comfortable and enjoyable (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 _______________