Health Form

For Office Use Only

Special Instructions:

Child's Name: _____
Age: _____ Weight: _____ Height: _____ Sex: _____

Parent's Name _____
Address: _____
Home Phone: _____ Cell Phone _____
Work Phone: _____ Alt. Phone: _____

Parent's Name _____
Address: _____
Home Phone: _____ Cell Phone _____
Work Phone: _____ Alt. Phone: _____

Doctor's Name: _____ Phone: _____
Address: _____
Dentist's Name: _____ Phone: _____
Address: _____
Health Insurance Company: _____
Policy or Group #: _____

In Case of Emergency (if parents cannot be reached) please contact:
Name: _____
Relationship to Child: _____ Phone: _____
Address: _____

Medical History
Please describe any health conditions and their treatment where necessary:

Yes No Is your child under treatment for any illness or condition?
Describe _____

Yes No Does your child have any fears or phobias?
Describe _____

Yes No Does your child have any mental or physical disabilities? (Depression, ADD, Hearing, etc.)
Describe _____

Yes No Does your child have a history or respiratory problems?
Describe _____

LXH, LLC - Legion of eXtraordinary Humans
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1103 San Augustine Drive, Austin, Texas 78733

Health Form

Yes No Does your child have a history of asthma?
Describe _____

Yes No Has your child been directed to carry an inhaler or other breathing device?
Describe _____

Yes No Does your child have any allergies, food, drug, or non-drug?
Describe _____

Yes No Is your child allergic to bee stings? (check here if you don't know _____)
If yes, answer the following questions:
Yes No Has your child been directed to carry an epi kit?
Yes No Will it be with your child at the LXH Camp
Yes No Does your child have a history of heart problems?
Describe _____

Yes No Does your child wear glasses?
Yes No If yes, are they required at all times?

Yes No Has your child had any major injuries i.e. head, back, neck, knees, or broken bones?
Describe _____

Yes No Is your child on a special diet?
Describe _____

Yes No Is there any physical activity your child's doctor has restricted your child from doing?
Describe _____

Yes No Does your child have a condition requiring regular medication (diabetes, epilepsy, etc)?
Describe _____

Yes No Does your child take psychotropic or mood altering drugs prescribed by a doctor?
Describe _____

Yes No If yes, has the dosage changed within the past three months?
Describe _____

Yes No Will your child be bringing medication to camp?
Name of medicine, for what illness, dosage and times taken: _____
_____

Yes No If your child takes medication, does the medication effect your child's health in certain situations such as strenuous exercise, hot weather, dehydration, direct sunlight, etc?
Describe _____

Yes No I have answered the above questions accurately and completely.

Yes No I believe that my child is in good health, and I affirm that his/her participation in LXH programs will in no way aggravate any conditions present. If in doubt, I will seek and follow medical advice for my child.

Yes No The staff at LXH has my permission to seek and/or administer emergency care to my child in the event that I am unable to respond.

Parent's Signature: _____ Date:_____/_____/_____

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