Health History Form
Waiver for Sol Camps International

Student name: _______________________ Date Of Birth_____________ Gender: ________

Home Address: ______________________ Phone Number: __________

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Parent/Legal Guardian:________________ Phone Number: ____________
Emergency Contact: __________________ Phone Number: ____________

Does your child have any concerns with the following? Please check all that apply

_ Asthma _ Sleep Walking _Food Allergies _ Diabetes _ Bed Wetting

_ Medication Allergies _ Hearing Loss _ Skin conditions _ Environmental Allergies

_ Heart Problems _ Seizures _ Allergies to insect stings _ Physical disability

_ Dietary needs _ Anaphylactic _ Lice* _ Other

Please details any symptoms of any of the above concerns, limitations, recent illnesses, operations or injuries
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List any medications that your child must take on a regular schedule

Name of medications: __________________________ Dosage: _____________________________

How often: ______________ When: ______________________________

- Please note that Sol Camps will perform a lice check at the beginning of the program. If a child is proved to have lice, he/she or the family will take financial responsibility for all the incurring costs of treating all students in the program. Please make sure you check your child before he arrives at the program.

Name and signature of parent/legal guardian: Date:

_____________________________ ______________