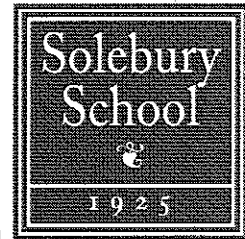


International Student Preliminary Health Report



ESL Full-Year Program Non-ESL Student ESL Spring Program ESL Summer Program

Solebury School, 6832 Phillips Mill Road, New Hope, PA 18938-9682 USA 215-862-5261 Fax: 215-862-3366 E-mail: admissions@solebury.org

Name of Candidate _____

Address _____

City _____ State _____ Zip _____ Country _____

Age _____ Height _____ Weight _____ Present Grade _____

1. Are you presently under medical treatment? Yes No
If yes, please give reasons, and names, addresses, and phone numbers of doctors.

2. Are there medications that you are taking, and/or will be taking during the school year? Yes No
If yes, please list and include dosages.

3. Has your school attendance ever been interrupted for a period of a week or more due to medical problems? Yes No
If yes, please give reasons and approximate dates.

4. Are your physical activities restricted in any way? Yes No
If yes, please explain.

5. *Have you received professional counseling from a psychiatrist, psychologist or family doctor? Yes No
If yes, please indicate inclusive dates of treatment, reason for treatment and give names, addresses, and phone numbers of doctors.

Reason for Treatment: _____ Dates of Treatment: _____

Name of Doctor: _____

Address of Doctor: _____

6. *It is Solebury's intention to guard the health of our campus, and we therefore ask if you have ever tried or used alcohol, marijuana, or other illegal drugs? Yes No
If yes, give details.

** A history of counseling or experimentation with drugs may not disqualify an applicant, but it will be made a part of the evaluation process. A frank answer to these questions will help us in our understanding of the applicant should he/she be admitted.*

7. Name, address, and phone number of your present doctor.

Name

Address

City

State

Zip

Telephone

Telephone

8. Is there any other pertinent information which would aid us in our evaluation process or in working with you?

Date

Signature of Candidate

I have read the above and certify that no information concerning the health of this student has been withheld or misrepresented. I authorize the School to obtain further medical history and reports or records from doctors or counselors listed above should it be necessary. I acknowledge that inclusion of false information on this form will require re-evaluation of the student, and could become grounds for dismissal without tuition refund.

Date

Signature of Parent/Guardian

Thank you for your help. Please return directly to:

Director of Admission, Solebury School, 6832 Phillips Mill Road, New Hope, PA 18938-9682 USA 215-862-5261 FAX: 215-862-3366