QSI INTERNATIONAL SCHOOL OF YEREVAN

Vahagni Community Section 12
Ashtarak Highway 49/15
+374-10-349130
yerevan@qsi.org
www.qsi.org

Student Health History Form

School Year: 2020-2021

Parent Information**: We would like your child to gain the most from his/her school experience. Please fill out this brief health history form on your child. This information will help the school nurse to better understand your child and assist in the transition into school life.* ***Please complete this form and return it with a copy of your child's most recent physical exam and vaccinations.

STUDENT NAME: _____ **Date of Birth:** _____

Student Permanent Address: _____

If you have a preference for a Doctor or Hospital, please indicate below.

Pediatrician/General practitioner/Surgeon/Dentist/Nurse

1. **Name:** _____**Phone:** _____
2. **Name:** _____**Phone:**_____
3. **Name:** _____**Phone:**_____

To the best of your knowledge, does your child have any problems that may affect his/her learning in school, cause any concern and/or be important for school staff to know?

Allergies: ☐ **No** ☐**Yes:** ☐ **Food** ☐ **Insect** ☐ **Latex** ☐ **Medicine** ☐ **Unknown source**

If yes, please provide a copy of the ***Emergency Allergy Action Plan*** *to School Nurse*

History of Anaphylaxis: ☐ **No** ☐ **Yes** **Epi Pen required:** ☐ **No** ☐ **Yes**

With regard to life threatening allergies, check the signs that usually appear during your child's allergic response:

_____ Difficult breathing
_____ Difficult swallowing
_____ Loss of consciousness
_____ Swelling:
How much? _____
Where? _____
_____ Rash/ hives
_____ Nausea
_____ Flushed skin color
_____ Unusually pale skin color
_____ Other: _____
_____ Other: _____

Asthma: ☐ **No** ☐ **Yes:** ☐ **Intermittent** ☐ **Mild Persistent** ☐ **Moderate Persistent**
☐ **Sever Persistent** ☐ **Exercise induced**

If yes, please provide a copy of the ***Asthma Action Plan*** *to School Nurse* *Please turn over*

Medical Conditions:

Diabetes or hypoglycemia	☐ **No**	☐ **Yes**	***ADD/ADHD**	☐ **No**	☐ **Yes**
Seizure disorder	☐ **No**	☐ **Yes**	**Psychological/psychiatric**	☐ **No**	☐ **Yes**
Heart disease /murmur	☐ **No**	☐ **Yes**	**Gastro/Intestinal problems**	☐ **No**	☐ **Yes**
High blood pressure	☐ **No**	☐ **Yes**	**Bladder/Kidney disease**	☐ **No**	☐ **Yes**
Headaches/migraines	☐ **No**	☐ **Yes**	**Lung disease**	☐ **No**	☐ **Yes**
Concussion/head injury	☐ **No**	☐ **Yes**	**Skin disorders**	☐ **No**	☐ **Yes**
Fainting/dizziness	☐ **No**	☐ **Yes**	**Bone/joint problems**	☐ **No**	☐ **Yes**
Bleeding/clotting disorder	☐ **No**	☐ **Yes**	**Scoliosis**	☐ **No**	☐ **Yes**
Speech impairment	☐ **No**	☐ **Yes**	**Chickenpox**	☐ **No**	☐ **Yes**
Reduced hearing ability	☐ **No**	☐ **Yes**	**Surgery/Hospitalization**	☐ **No**	☐ **Yes**
Poor vision/correction	☐ **No**	☐ **Yes**	**Frequent colds**	☐ **No**	☐ **Yes**

*Attention Deficit Disorder

Please explain all "yes" answers here. For illnesses/injuries/etc., include the year and/or your child's age at the time: _____

_____

Does your child have any other medical conditions? ☐ **No** ☐ **Yes**

If yes, please explain: _____

Is your child currently under medical treatment? ☐ **No** ☐ **Yes**

If yes, please explain: _____

Is your child taking medication (prescription or over-the-counter) on a regular basis? ☐ **No** ☐ **Yes**

If yes, please explain: _____

Does your child need medicine during school hours? ☐ **No** ☐ **Yes**

***If yes, please contact the school nurse to make arrangements.**

Does your child have any dietary restrictions/intolerance? ☐ **No** ☐ **Yes**

Should there be any restriction of Physical Activity in school? ☐ **No** ☐ **Yes**

If yes, please explain: _____

May your child participate in the Physical Education class? ☐ **No** ☐ **Yes**

If no, please explain: _____

Immunizations: ☐ **Not updated** ☐ **Updated**

*Please provide a copy of the **Immunization Record** to School Nurse*

Has your child ever been examined by an Eye doctor? ☐ **No** ☐ **Yes** **Glasses Prescribed:** ☐ **No** ☐ **Yes**

If your child wears glasses or contact lenses, when the prescription was last changed: _____

Has your child had any emotional upsets? ☐ **No** ☐ **Yes**

Is there anything you want to discuss with the school nurse? ☐ **No** ☐ **Yes**

***If yes, please contact the school nurse to make arrangements.**

I do acknowledge that for my child's safety it is necessary for the school nurse to notify school administrators and personnel who work with my child the following medical conditions: bee sting allergy, other insect allergies, food allergy, asthma, seizures, and diabetes.

_____	_____	_____
Parent/Guardian Name	Parent/Guardian Signature	Date

Thank You for completing this form.