QSI INTERNATIONAL SCHOOL OF TBILISI

Student Health Form

Student Name _____ Date of Birth (mm/dd/yyyy) _____

Health History:

Does your child have:

• Allergies	☐Yes ☐No *If yes, please explain* _____
• Asthma	☐Yes ☐No *If yes, please explain* _____
• Diabetes	☐Yes ☐No *If yes, please explain* _____
• Heart Disease	☐Yes ☐No *If yes, please explain* _____
• Seizures	☐Yes ☐No *If yes, please explain* _____
• Headaches/Migraines or Head Injury/Concussion	☐Yes ☐No *If yes, please explain* _____
• Stomach/Gastro-Intestinal problems	☐Yes ☐No *If yes, please explain* _____
• ADHD/ADD/Autism or other Special Need	☐Yes ☐No *If yes, please explain* _____
• Speech, Hearing or Vision Impairment	☐Yes ☐No *If yes, please explain* _____
• Hospitalization/ Surgery/ Broken Bones	☐Yes ☐No *If yes, please explain* _____

Is your child on medication?

☐Yes ☐No *If yes, please provide details* _____

Does your child have a health condition other than listed above that the school needs to know about? ☐Yes ☐No

If yes, please explain _____

Immunization: Please provide a copy of the vaccination book or list vaccines here

	Dates of Immunization				
DTAP (Diphtheria, Tetanus Pertussis)	1)	2)	3)	4)	5*)
IPV or **OPV** (Polio)	1)	2)	3)	4)	
(Haemophilus Influenza b)	1)	2**)	3)	4)	
PCV (Pneumococcal)	1)	2***)	3)	4)	
HEPATITIS B	1)	2)	3)		
MMR (Measles, Mumps, Rubella)	1)	2)			
VARICELLA (Chicken pox)	1)	2)			
HEPATITIS A	1)	2)			
BCG (Tuberculosis)/**TB** Skin test (Mantoux)					
INFLUENZA 2015 (Flu)					
TDAP (DTaP for >7yo) ****					
Other					
Other					

*5th dose not necessary if 4th dose given > 4 yo

** no further dose needed if prev. dose given > 15 mo

*** no further dose needed if prev. dose was given > 24 mo

**** if DTaP series is incomplete. If complete, then booster > 11yo

This chart is based on the recommended immunization schedule from CDC.gov effective as of January 1st, 2015.

I acknowledge that for the health and safety of my child this information will be shared on a need to know basis with teachers, school management and, in case of emergency, also with emergency medical staff, unless notified otherwise.

Name: _____ Date: _____

* Typing your name above constitutes your signature.