

Serious Medical Issue!
See Page Four.

QUALITY SCHOOLS INTERNATIONAL
BAKU INTERNATIONAL SCHOOL
Darnagul Qasabasi, Str.Ajami Nakhchivani, Block 3097
Baku, Azerbaijan, AZ1108

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Director: Mrs. Lisa Haberman

Digital Picture
will-be-taken
by the school

Family Name: _____ Expected Date of Entry: _____

Given Names: _____ Citizenship: _____

Date of Birth: _____ / _____ / _____
Day Month Year

Verification (copy): Birth Certificate Passport
 Travel Document

Parental/Guardian Information:

Father's Name: _____ Occupation: _____

Company: _____ E-Mail Address: _____

Home Phone Number: _____ Work Phone Number: _____

Mobile Phone Number: _____ Address: _____

Mother's Name: _____ Occupation: _____

Company: _____ E-Mail Address: _____

Home Phone Number: _____ Work Phone Number: _____

Mobile Phone Number: _____ Address: _____

Please list the email addresses you would like to use
for school communication. _____

Choice of Foreign Language: Russian French Italian
(Students 6 yrs. old and older)

Organization Responsible for Fees: _____

Company personal government Other: _____

Additional payment directions, provisions, or concerns:

Preschool only: _____ Half day _____ Full day _____

School History: List previous three schools attended including partial years, if applicable: (*last school first*)

| Levels Attended (<i>check all that apply</i>) | Name of School |
|---|--|
| <input type="checkbox"/> Pre-Kindergarten <input type="checkbox"/> Kindergarten <input type="checkbox"/> 1 st Grade <input type="checkbox"/> 7 th Grade <input type="checkbox"/> 2 nd Grade <input type="checkbox"/> 8 th Grade <input type="checkbox"/> 3 rd Grade <input type="checkbox"/> 9 th Grade <input type="checkbox"/> 4 th Grade <input type="checkbox"/> 10 th Grade <input type="checkbox"/> 5 th Grade <input type="checkbox"/> 11 th Grade <input type="checkbox"/> 6 th Grade <input type="checkbox"/> 12 th Grade | |
| | Location (<i>city & country</i>) |
| | |
| | Dates attended (<i>month/year – month/year</i>) |

| Levels Attended (<i>check all that apply</i>) | Name of School |
|---|--|
| <input type="checkbox"/> Pre-Kindergarten <input type="checkbox"/> Kindergarten <input type="checkbox"/> 1 st Grade <input type="checkbox"/> 7 th Grade <input type="checkbox"/> 2 nd Grade <input type="checkbox"/> 8 th Grade <input type="checkbox"/> 3 rd Grade <input type="checkbox"/> 9 th Grade <input type="checkbox"/> 4 th Grade <input type="checkbox"/> 10 th Grade <input type="checkbox"/> 5 th Grade <input type="checkbox"/> 11 th Grade <input type="checkbox"/> 6 th Grade <input type="checkbox"/> 12 th Grade | |
| | Location (<i>city & country</i>) |
| | |
| | Dates attended (<i>month/year – month/year</i>) |

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| <input type="checkbox"/> Pre-Kindergarten <input type="checkbox"/> Kindergarten <input type="checkbox"/> 1 st Grade <input type="checkbox"/> 7 th Grade <input type="checkbox"/> 2 nd Grade <input type="checkbox"/> 8 th Grade <input type="checkbox"/> 3 rd Grade <input type="checkbox"/> 9 th Grade <input type="checkbox"/> 4 th Grade <input type="checkbox"/> 10 th Grade <input type="checkbox"/> 5 th Grade <input type="checkbox"/> 11 th Grade <input type="checkbox"/> 6 th Grade <input type="checkbox"/> 12 th Grade | |
| | Location (<i>city & country</i>) |
| | |
| | Dates attended (<i>month/year – month/year</i>) |

Strengths and Challenges:

This student...

- has been identified gifted or talented.
- attended a gifted or talented program.
- has been an honor student.
- is an accelerated reader.
- is athletic by nature.

- has been identified ADHD.
- has been identified ADD.
- has been diagnosed dyslexic.
- has been diagnosed having Asperger’s Syndrome.
- is autistic.

Excels in the following subjects:

- all subjects
- Mathematics
- Language Arts
- Reading
- Science
- Cultural Studies
- Art
- Music
- Physical Education

Struggles in the following subjects:

- all subjects
- Mathematics
- Language Arts
- Reading
- Science
- Cultural Studies
- Art
- Music
- Physical Education

- has a long attention span.
- is highly focused.
- is competitive.

- tends to have a short attention span.
- has been expelled from a school.
- has been removed from a program for behavioral issues.

Please expound below on any items marked:

Parental information:

| | |
|--|--------------------------------|
| <input type="checkbox"/> Parent <input type="checkbox"/> Guardian | Name of Parent/Guardian |
| Lives with Student | Occupation |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | |

| | |
|--|--------------------------------|
| <input type="checkbox"/> Parent <input type="checkbox"/> Guardian | Name of Parent/Guardian |
| Lives with Student | Occupation |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | |

Sibling information:

| | |
|---|------------------------|
| Sex | Name of Sibling |
| <input type="checkbox"/> Male <input type="checkbox"/> Female | |
| Age | |
| <input type="checkbox"/> 0-2 years <input type="checkbox"/> 10-13 years <input type="checkbox"/> 3-5 years <input type="checkbox"/> 14-19 years <input type="checkbox"/> 6-9 years <input type="checkbox"/> Adult | |

| | |
|---|------------------------|
| Sex | Name of Sibling |
| <input type="checkbox"/> Male <input type="checkbox"/> Female | |
| Age | |
| <input type="checkbox"/> 0-2 years <input type="checkbox"/> 10-13 years <input type="checkbox"/> 3-5 years <input type="checkbox"/> 14-19 years <input type="checkbox"/> 6-9 years <input type="checkbox"/> Adult | |

| | |
|---|------------------------|
| Sex | Name of Sibling |
| <input type="checkbox"/> Male <input type="checkbox"/> Female | |
| Age | |
| <input type="checkbox"/> 0-2 years <input type="checkbox"/> 10-13 years <input type="checkbox"/> 3-5 years <input type="checkbox"/> 14-19 years <input type="checkbox"/> 6-9 years <input type="checkbox"/> Adult | |

| | |
|---|------------------------|
| Sex | Name of Sibling |
| <input type="checkbox"/> Male <input type="checkbox"/> Female | |
| Age | |
| <input type="checkbox"/> 0-2 years <input type="checkbox"/> 10-13 years <input type="checkbox"/> 3-5 years <input type="checkbox"/> 14-19 years <input type="checkbox"/> 6-9 years <input type="checkbox"/> Adult | |

Language Information:

Primary (first) language is: _____ Language spoken in home: _____

Secondary language: _____ Other: _____

Any background information pertinent to language development: _____

Please expound upon activities or sports that are of particular interest to this student:

Student Health History

| | Yes | No | For "Yes" answers, please explain here. |
|--|--------------------------|--------------------------|---|
| 1) Does your child have any allergies (medications, foods, insects, or to other substances such as latex, tape, certain chemicals)? If yes, please list allergy, type of reaction, and treatment required for each allergy. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 2) Does your child have any chronic health problems, such as asthma, seasonal allergies, seizures, diabetes, anemia, attention deficit disorder, or others? If yes, please explain when your child was diagnosed with this health problem(s) and how it is currently treated. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 3) Did your child experience any complications in the pre-natal, delivery, or post-natal periods? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 4) Does your child have any past or present sleeping or eating problems? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 5) Does your child have any other current or past developmental, emotional, behavioral or psychiatric conditions that may affect his or her school and extracurricular activities? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 6) Does your child have any current or suspected problems with vision, hearing, or speech (glasses, contacts, hearing aids, lisp, etc)? If yes, please list these and current types of treatment for each problem. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 7) Does your child have any implanted medical devices, such as a cochlear implant, rod or pin in a bone, artificial joint, or other? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> | |
| | | | |

| | Yes | No | For "Yes" answers, please explain here. |
|--|--------------------------|--------------------------|---|
| 8) Does your child have any current dental issues? Does your child have any dental appliances, such as braces, retainers, or bridges? If yes, please explain. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 9) Do you know, with absolute certainty, your child's blood type? If yes, please note. | <input type="checkbox"/> | <input type="checkbox"/> | |
| 10) Family history: Does your child have any blood relatives who experienced a sudden, unexplained death before reaching 50 years old? | <input type="checkbox"/> | <input type="checkbox"/> | |
| 11) Does your child have any immediate family members (mother, father, sibling) with elevated cholesterol or heart disease? | <input type="checkbox"/> | <input type="checkbox"/> | |

12) Please place a check/tick next to any health problems your child has experienced:

| | | | |
|---|-------------------------------------|---------------------------------------|-------------------------------------|
| | <input checked="" type="checkbox"/> | | <input checked="" type="checkbox"/> |
| Hospital or emergency room visit in past year | | Problems with breathing or coughing | |
| Broken bone/dislocation | | Chest pain | |
| Back injury or problem | | Heart problems | |
| Muscle/joint injury | | High blood pressure | |
| Trouble running | | Bleeding—more than expected | |
| Concussion | | Excessive weight gain or loss | |
| Constipation/intestinal problems | | History of one kidney or one testicle | |
| Fainting/dizzy spell/passing out | | Other: | |

For any checked items, please explain:

13) Immunizations-- Please record dates of immunization administration for each vaccine or attach a copy of your child's most recent immunization records:

| | |
|-----------------------------------|-----------------------------------|
| Diphtheria _____ | Varicella(chicken pox) _____ |
| Tetanus _____ | Meningitis _____ |
| Pertussis (whooping cough) _____ | Human papilloma virus (HPV) _____ |
| Polio _____ | BCG(tuberculosis) _____ |
| Measles _____ | Typhoid fever _____ |
| Mumps _____ | Rabies _____ |
| Rubella _____ | Yellow fever _____ |
| Haemophilus Influenza (Hib) _____ | Influenza _____ |
| Hepatitis A _____ | Others _____ |
| Hepatitis B _____ | |

14) Has your child had any of the following illnesses?

| | Yes | No | Date |
|--------------|-----|----|------|
| Measles | | | |
| Mumps | | | |
| Rubella | | | |
| Chicken pox | | | |
| Malaria | | | |
| Tuberculosis | | | |
| Other: | | | |

15) Does your child have any medications (prescription or over-the-counter) that will need to be taken routinely while at school? If yes, you will need to complete a medication administration form provided by the school. Please list the medications:

(If your child will need to take medications temporarily during the school day like antibiotics, steroids, or over-the-counter medicines, BIS asks that medications be brought by the parent to the school health office for administration. A medication administration form may be completed at that time.)

16) Our health office keeps certain medications on hand. **Please indicate below which medications may be administered to your child on an “as needed” basis.** You will be notified via written note of all school medicines provided to your child.



| | |
|---|--|
| Acetaminophen (“Tylenol”, “Paracetamol”, “Panadol”, “Calpol”) for pain or fever | |
| Ibuprofen (“Nurofen”, “Motrin”) for pain, inflammation | |
| Antihistamine for allergic reaction, hives (diphenhydramine, “Claritin”, “Benadryl”) | |
| Normal Saline (wound irrigant, eye irrigant) | |
| Topical hydrocortisone for insect bites, itching, rash (“cortisone”) | |
| Betadine for cleansing of wounds | |
| Aquaphor for cracked/chapped lips | |
| Burn ointment/gel | |
| Throat lozenges (strepsils) for sore throat | |
| Antibiotic ointment for scrapes and cuts | |
| NO MEDICINES TO BE GIVEN TO CHILD | |

17) Do you have any specific health or wellness concerns for your child that you would like to discuss with the BIS school nurse?

18) BIS policy is to send all children with urgent or life-threatening issues to the Medclub Clinic, in Baku. If you have a preference for a different doctor/clinic/hospital, please indicate name, address, and phone number below:

19) If emergency medical care is required, do you authorize school authorities to initiate medical care that may include locating a doctor/nurse or transporting your child to a medical facility for treatment? Please circle: YES or NO

(printed parent/legal guardian name) (signature) (date)

20) Parent/Guardian contact information:

(mother/guardian name) (mobile) / (other)

(father/guardian name) (mobile) / (other)

21) Please provide contact information for two LOCAL individuals that the BIS school nurse can telephone, if unable to reach either parent/guardian.

(name) (mobile) / (other)

(name) (mobile) / (other)

Note: A non-reimbursable one-time registration fee of \$300 is required for each new student.