

**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*)

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

<b>Levels Attended</b> ( <i>check all that apply</i> )	<b>Name of School</b>
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	<b>Dates attended</b> ( <i>month/year – month/year</i> )

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	<b>Location</b> ( <i>city &amp; country</i> )
	<b>Dates attended</b> ( <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:

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**Parental information:**

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

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

**Sibling information:**

<b>Sex</b>	<b>Name of Sibling</b>
<input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>Age</b>	
<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	

<b>Sex</b>	<b>Name of Sibling</b>
<input type="checkbox"/> Male <input type="checkbox"/> Female	
<b>Age</b>	
<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	

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**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.
<b>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.</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>9) Do you know, with absolute certainty, your child's blood type? If yes, please note.</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>10) Family history: Does your child have any blood relatives who experienced a sudden, unexplained death before reaching 50 years old?</b>	<input type="checkbox"/>	<input type="checkbox"/>	
<b>11) Does your child have any immediate family members (mother, father, sibling) with elevated cholesterol or heart disease?</b>	<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:

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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:

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(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.



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

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

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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:

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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.