QSI INTERNATIONAL SCHOOL OF KOSOVO
https://kosovo.qsi.org | kosovo@qsi.org

QSI International School of Kosovo
Veternik, St. Mehmet Gjevori,
10000 Pristina, Kosovo
Tel: +383 49 775 731

Student Health Information 2022-2023

An Important Message From Your Child's School Nurse:

In order for the school to have the most current health information on your children and to help your student have a healthy and successful year, please complete and return this form to the teacher or school nurse. If you have any questions completing this form or need to talk with your school nurse, please do not hesitate to contact the school office and ask to speak with the school nurse. Thank you for your cooperation!

CHILD HEALTH INFORMATION (to be completed by parent/guardian):

Student's Full Name: _____ Birth Date:___/___/___ Gender:_____

Address:_____ City: _____ ZIP:_____

School:_____ Homeroom Teacher:_____ Grade:_____

Parent/Guardian Full Name:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Email- Adress:_____

Emergency Contact:_____

Home phone:_____ Work Phone:_____ Cell Phone:_____

Family Physician:_____ Phone:_____

Dentist:_____ Phone:_____

Eye Doctor:_____ Phone:_____

Health Insurance Provider:_____

Phone:_____ Policy Number:_____

Date of most recent Tetanus shot/booster:_____ Glasses/Contacts worn:_____

Allergy History:

List any drug allergies: _____

List any food allergies:_____

List any allergies to insect bite:_____

List any allergies to materials: _____

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Is emergency medication required for this allergy? _____

Does your child have any condition or limitation the School Nurse or School Office should know about to assure his/her well being at youth events or activities? YES or NO

If yes, please explain_____

Does your child have a chronic/ongoing health condition?
YES or No (If **YES,** please complete the form below).

MEDICAL HISTORY

CHRONIC CONDITION	**YES**	**NO**
ADHD		
ASTHMA		
DIABETES (Type I or Type II)		
EPILEPSY		
HYPERTENSION or HYPOTENSION		
OTHER		

May the School Nurse administer any of the following to your child?

SYMPTOMS	**TREATMENT**	**YES**	**NO**
Fever,flu,headache	Acetaminophen		
Sore throat, cough	Acetaminophen, Lozenges		
Allergy, hives,bites	Loratadine		
Burns	Silver Sulfadizin cream, Acetaminophen		
Nose congestion	Nafazolin HCL 1 mg, Saline drops		
Indigestion, dehydration	Lactis B-Complex, Hydralate, Acetaminophen		

I give permission for my child to receive the above medication as indicated by **"YES"** column. Before treatment is provided for any other illness or injury, parental contact or physician advice will be sought. I will notify the QSI International School of Kosovo if my child is exposed to any communicable disease during the two weeks prior to attending any function.

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Does your child:

Take any medication(s) at home daily? **YES** or **NO**

Name of medication(s):_____

Take medication(s) at school? **YES** or **NO**

Name of medication(s):_____

Time of the day:_____ Dosage:_____

All medication, both prescription and non-prescription, that is sent into school must have a physician's written order with it, in order for the school nurse to dispense the medication. All medications must be brought directly to the nurse's office. Medications must be stored in their original containers in a locked cabinet in the health office and administered only by the School Nurse.

PERMISSION TO TREAT (must be signed by parent or legal guardian)

In the event of an emergency, school staff will attempt to contact the listed parents or guardians. If the school is unable to reach a parent or legal guardian, the undersigned authorizes the school staff to make whatever arrangements it deems necessary for the health and safety of the child.

I hereby give consent for licensed health providers to carry out accepted procedures for diagnosis, immunization, medical and minor surgical treatment, or counseling for my son or daughter. In the event that I cannot be reached, I also hereby give my consent for the emergency treatment for the above-named QSI International School of Kosovo student according to the judgement of the attending physician, nurse, athletic trainer.

Signature of Parent or Legal Guardian **Date:___/___/_____**

_____ Print Name_____