QSI INTERNATIONAL SCHOOL of MALTA

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STUDENT INFORMATION FORM

SCHOOL HISTORY Name of student_____

List of schools previously attended: (list last school first)

Level	Name of school	Location	Dates attended

Special interests or hobbies_____

Has student been in any special program? Yes_____ No_____
If Yes, specify:

_____

Please attach student's records from previous schools. For students entering Secondary I-IV, a complete list of all schools within the last 4 years is required along with transcripts. This information is used to create a graduation profile for the student. For all other students, records from the previous 2 years are required.

FAMILY HISTORY:

Parental information:

Complete name	Occupation	Place of employmen	Lives with student Yes/ No
Father/Guardian			
Mother/Guardian			

Additional information on family relationships:

_____

Language Information:

Primary (first) language is _____
Language spoken in home _____
Secondary language _____
Other _____
Comments: (Any background information pertinent to language development)

_____

_____

HEALTH HISTORY:

Does your child take any medication? Yes_____ No_____

If Yes, explain _____

Does your child have a health condition that school personnel should know about?

Yes_____ No_____ If Yes, explain _____

_____

Does your child have any food allergies?

Yes_____ No_____ If Yes, explain severity and procedures for emergency:____

_____

_____

Immunization Information: Record dates of initial childhood and last immunization:

Diptheria_____
Tetanus_____
Pertussis (Whooping Cough)_____
Polio_____
Measles_____
Mumps_____
Rubella_____
Yellow Fever _____

BCG _____
Meningitis_____
Typhoid Fever_____
Rabies_____
Hemophilus Influenza_____
Hepatitis B_____
Hepatitis A _____
Other _____

Developmental Information:

Were there any complications in the pre-natal, delivery, or post-natal periods?

Yes_____ No_____ If Yes, explain_____

_____

Any present or past sleeping or eating problems? Yes_____ No_____

If Yes, explain_____

_____

Please check the following items where appropriate and give date of occurrence:

Broken bones_____
Hospitalizations/operations_____
Intestinal problems_____
Hay-fever_____
High temperatures_____

Allergies_____
Seizure_____
Hearing_____
Vision (corrective lenses)_____
Other_____

If any of the above items are checked, please give additional details.

_____