QSI

INTERNATIONAL SCHOOL OF BRATISLAVA

STUDENT HEALTH FORM

SCHOOL YEAR 2019-2020

STUDENT NAME _____ DATE OF BIRTH*(**mm**/dd/yyyy)* _____

HEALTH HISTORY

- Does your child have an allergy?

☐Yes ☐No ☐Mild ☐Severe Please explain to what? What happens? Treatment? EpiPen prescribed – name and dose? _____

- Does your child have asthma?

☐Yes ☐No ☐Mild ☐Severe Please explain what causes an asthma attack? What happens? Treatment? Inhaler prescribed – name and dose? _____

- Does your child have diabetes?

☐Yes ☐No ☐Type 1 ☐Type 2 Treatment? _____

- Does your child have heart disease?

☐Yes ☐No Treatment? _____

- Does your child have/had seizures?

☐Yes ☐No Treatment? _____

- Does your child have frequent headaches/migraines or a history of head injury/concussion?

☐Yes ☐No Therapy? _____

- Does your child have frequent stomach/gastro-intestinal problems?

☐Yes ☐No Therapy? _____

- Does your child have ADHD/ADD/Autism or other special need?

☐Yes ☐No Therapy? _____

- Does your child have any speech, hearing or vision impairment?

☐Yes ☐No Therapy? _____

- Does your child had any hospitalization/surgery/broken bones?

☐Yes ☐No Treatment? _____

- Is your child on medication treatment?

☐Yes ☐No Please explain medication name and dose? Does your child need medicine during school hours? _____

- Does your child have a health condition other than listed above that the school nurse should know about?

☐Yes ☐No Health condition? _____Treatment/Plan?_____

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Please turn over

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** (Pollo)	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 January1, 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.

_____ _____

Parent/Guardian Signature Date ***(mm**/dd/yyyy)*

Záhradnícka 1006/2,
93101 Šamorín, Slovakia
Phone: +421-903 704 436

Website: *www.qsi.org/slovakia/svk*
Facebook: *www.facebook.com/qsi.bratislava*
Email: *office@svk.org*