



# QSI International School of Sarajevo

## Health Appraisal Form

Child's Name: \_\_\_\_\_

Last

First

Middle

Today's Date \_\_\_\_\_ Date of Birth \_\_\_\_\_

### Section I Health History

Does your child have any of the following:

Please explain any areas in detail in the space provided:

	YES	NO	
1. Allergies or reactions: (for example, food, medication, latex, or other)			
2. Hay fever, asthma, or wheezing			
3. Eczema or frequent skin rashes			
4. Convulsions/Seizures			
5. Heart trouble			
6. Diabetes			
7. Frequent colds, sore throats, earaches (4 or more per year)			
8. Trouble passing urine or bowel movements			
9. Speech problems			
10. Dental problems			
11. Vision problems			
12. Shortness of breath			
13. Other			

Does your child take any medications regularly? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes what medication? \_\_\_\_\_

Reason for the medication: \_\_\_\_\_

Will it be necessary to administer the medication while during school hours? \_\_\_\_\_

### Section II Immunizations

Please complete the entire form; information such as "complete" or "up to date" is not acceptable

VACCINE TYPE DATE ADMINISTERED (Mo/Day/Yr.)

DtaP/DTP/Td (Diphtheria, Tetanus, pertussis)		
Haemophilus influenza type b (HIB)		
POLIO IPV/OPV		
MMR (Mumps, Measles, Rubella)		
Varicella (Chickenpox)		
Pneumococcal Conjugate (PCV)		
Hepatitis B (HBV)		



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Hepatitis A (HAV)		
Typhoid Fever		
Other Vaccines		

Vaccines waived due to reactions/contraindications/religious objections:

Parents Signature

I certify that the immunization dates are true to the best of my knowledge:

Parents Signature

**Section III Developmental Information**

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

Yes \_\_\_\_\_ No \_\_\_\_\_ If Yes explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Are there any present or past sleeping or eating problems?

Yes \_\_\_\_\_ No \_\_\_\_\_ If Yes explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

Yes \_\_\_\_\_ No \_\_\_\_\_ If Yes explain: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Should your child's activity be restricted because of any physical defect or illness?

Yes \_\_\_\_\_ No \_\_\_\_\_

If so check the activity and explain the degree of restriction:

- \_\_\_\_\_ Classroom
- \_\_\_\_\_ Playground
- \_\_\_\_\_ Swimming Pool
- \_\_\_\_\_ Field trips
- \_\_\_\_\_ Other Clubs and activities

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

