



QSI INTERNATIONAL SCHOOL OF YEREVAN

DOUG SHIPPERT, DIRECTOR

P.O. Box 82, c/o American Embassy
0088 Yerevan Department of State
Ashtarak Highway, 2A 7020 Yerevan Place
Republic of Armenia Washington D.C. 20521-7020
Tel: 374.10.391.030 e-mail: yerevan@qsi.org
Fax: 374.10.397.599 http://www.qsi.org

Student Application Form

New Student Returning Student

Please return this form ASAP so that we may process it in a timely fashion

Last Name
First Name
Citizenship

Date of Birth Day Month Year Expected Date of Entry

Verification (copy) Birth Certificate Passport

Name or Parent / Guardian

(Title) Father's Name Occupation Company

(Title) Mother's Name Occupation Company

Local Mailing Address

Physical Address

Father Home Tel. Work Tel. Cell Tel.
e-mail

Mother Home Tel. Work Tel. Cell Tel.
e-mail

Organization responsible for school fees
(company, government, personal, etc.)

Please choose which language you would like your child to study Russian Armenian
 French German

Signature Date

Do you want your information to be entered in the school directory? Yes No



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Student Information Form

Student's Name

School History (List schools previously attended, starting with the last school first)

| Level | Name of School | Location | Dates Attended |
|-------|----------------|----------|----------------|
| | | | - |
| | | | - |
| | | | - |
| | | | - |
| | | | - |

Special interests or hobbies

Has student been in any special program(s)? Yes No

If yes, please specify

Please attach student's records from previous schools. If not available, please give full name and address of last school where records can be obtained.

Family History

| Full Name | Occupation | Place of employment | Lives with student |
|----------------------|----------------------|----------------------|--|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Father / Guardian | | | |
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Mother Guardian | | | |

Siblings (brothers and sisters)

| Name | Date of Birth | Sex M/F | Name | Date of Birth | Sex M/F |
|----------------------|----------------------|---|----------------------|----------------------|---|
| <input type="text"/> | <input type="text"/> | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="text"/> | <input type="text"/> | <input type="checkbox"/> M <input type="checkbox"/> F |
| <input type="text"/> | <input type="text"/> | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="text"/> | <input type="text"/> | <input type="checkbox"/> M <input type="checkbox"/> F |
| <input type="text"/> | <input type="text"/> | <input type="checkbox"/> M <input type="checkbox"/> F | <input type="text"/> | <input type="text"/> | <input type="checkbox"/> M <input type="checkbox"/> F |

Additional information on family relationships

Language Information

Primary (first) language Secondary Language
 Language spoken at home Other

Any background information pertinent to language development



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Health History

Does your child take any medication? Yes No

If yes, please specify

Does your child have a health condition that school personnel should know about? Yes No

If yes, please specify

Immunization Information (record dates of initial childhood and most recent immunization)

| | Initial | Most recent | | Initial | Most recent |
|--------------|----------------------|----------------------|----------------------------|----------------------|----------------------|
| Diphtheria | <input type="text"/> | <input type="text"/> | BCG | <input type="text"/> | <input type="text"/> |
| Tetanus | <input type="text"/> | <input type="text"/> | Meningitis | <input type="text"/> | <input type="text"/> |
| Rabies | <input type="text"/> | <input type="text"/> | Typhoid Fever | <input type="text"/> | <input type="text"/> |
| Polio | <input type="text"/> | <input type="text"/> | Pertussis (Whooping Cough) | <input type="text"/> | <input type="text"/> |
| Measles | <input type="text"/> | <input type="text"/> | Hemophilus Influenza | <input type="text"/> | <input type="text"/> |
| Mumps | <input type="text"/> | <input type="text"/> | Hepatitis B | <input type="text"/> | <input type="text"/> |
| Rubella | <input type="text"/> | <input type="text"/> | Hepatitis A | <input type="text"/> | <input type="text"/> |
| Yellow Fever | <input type="text"/> | <input type="text"/> | Others | <input type="text"/> | <input type="text"/> |

Developmental Information

Please indicate date of occurrence for any of the following items where appropriate

| | | | |
|-------------------------------|----------------------|--------------|----------------------|
| Broken bones | <input type="text"/> | Allergies | <input type="text"/> |
| Hospitalizations / operations | <input type="text"/> | Hay fever | <input type="text"/> |
| Intestinal problems | <input type="text"/> | Seizure | <input type="text"/> |
| High temperatures | <input type="text"/> | Hearing loss | <input type="text"/> |
| Vision (corrective lenses) | <input type="text"/> | Other | <input type="text"/> |

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

| |
|----------------------|
| <input type="text"/> |
| <input type="text"/> |
| <input type="text"/> |
| <input type="text"/> |



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Emergency Instructions

In the event a student is injured or for any other reason needs emergency attention, the following information is required

Student(s) Name

Telephone number(s) at which parents may be reached (if no phone contact is possible, please give an address or instructions on how to be reached)

Father Home Tel. Work Tel. Cell Tel.
Mother Home Tel. Work Tel. Cell Tel.

If unable to reach a parent, please indicate another person to contact

Name Relationship
Home Tel. Cell Tel.

If emergency medical care is required, do you authorize school authorities to initiate Yes No medical care, possibly to include locating a nurse or doctor?

If you have a preferred doctor or hospital, please indicate

Additional comments or instructions

In an emergency I authorize school authorities to take any steps necessary to administer medical treatment to my child(ren) in the event one of my child(ren)'s parents are not available at the time.

Signature

Date

