



QSI INTERNATIONAL SCHOOL OF CHONGQING

**STUDENT INFORMATION FORM**

Name of student \_\_\_\_\_

**SCHOOL HISTORY**

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 education program? Yes \_\_\_ No

If yes, 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**

Parental information:

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

Sibling information: (brothers and sisters)

Name	Birth Date	Sex

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:

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**HEALTH HISTORY:** (Attach immunization record)

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 \_\_\_\_\_

**IMMUNIZATION INFORMATION:** (Record dates of initial childhood and last immunization)

Diphtheria \_\_\_\_\_ BDG \_\_\_\_\_

Tetanus \_\_\_\_\_ Meningitis \_\_\_\_\_

Pertussis (Whooping Cough) \_\_\_\_\_ Typhoid Fever \_\_\_\_\_

Polio \_\_\_\_\_ Rabies \_\_\_\_\_

Measles \_\_\_\_\_ Hemophilus Influenza \_\_\_\_\_

Mumps \_\_\_\_\_ Hepatitis B \_\_\_\_\_

Rubella \_\_\_\_\_ Hepatitis A \_\_\_\_\_

Yellow Fever \_\_\_\_\_ Others \_\_\_\_\_

**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 \_\_\_\_\_ Allergies \_\_\_\_\_

Hospitalizations/operations \_\_\_\_\_ Seizure \_\_\_\_\_

Intestinal problems \_\_\_\_\_ Hearing \_\_\_\_\_

Hay-fever \_\_\_\_\_ Vision (corrective lenses) \_\_\_\_\_

High temperatures \_\_\_\_\_ Other \_\_\_\_\_

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