2552 Route 6
Hawley, PA 18428-7045
(570) 226-4557 opt. 6
Fax: (570) 226-0638

WALLENPAUPACK AREA SCHOOL DISTRICT

Health Registration Form

Student's Last Name *Student's First Name* *Date of Birth*

Immunization Records:
- ☐ Attached
- ☐ Medical Exemption Attached
- ☐ Religious Exemption Attached

Please check all that apply to your child - To be completed by parent

- ☐ Arthritis
- ☐ Asthma Triggers
  - ☐ allergies
  - ☐ exercise
  - ☐ infection
  - ☐ weather
- ☐ Attention Deficit
- ☐ Autoimmune Deficiency
- ☐ Bladder Control
- ☐ Bleeding Disorder/Anemia
- ☐ Bowel Control
- ☐ Chicken Pox
  - ☐ vaccine
  - ☐ disease
- ☐ Color Blindness
- ☐ Connective Tissue Disorder
- ☐ Cystic Fibrosis
- ☐ Dental Condition
- ☐ Developmental Delay
- ☐ Diabetes
- ☐ Dietary Restrictions
- ☐ Eating Disorder
- ☐ Fainting Spells
- ☐ Gastrointestinal Condition
- ☐ Headaches
- ☐ Hearing Deficit
- ☐ Heart Condition
- ☐ High Blood Pressure
- ☐ Kidney Condition
- ☐ Lung Condition
- ☐ Malignancy
- ☐ Neurological Disorder
- ☐ Neuromuscular Disorder
- ☐ Nosebleeds
- ☐ Orthopedic Condition
- ☐ Psychiatric Condition
- ☐ Seizures
- ☐ Skin Disorder
- ☐ Speech Difficulty
- ☐ TB Exposure
- ☐ Thyroid Condition
- ☐ Vision Deficit
  - ☐ severe loss
  - ☐ eye surgery
  - ☐ glasses/contacts
- ☐ Other (Specify)

If needed, please use reverse side to elaborate on the above conditions.

_____
_____
_____
_____

Family Physician – Please Print *Phone Number*

Family Dentist– Please Print

Last eye examination: Date:_____ by Dr._____

Last dental examination: Date:_____ by Dr._____

Last medical examination: Date:_____ by Dr._____

Parent/Guardian Signature Date

Please complete and sign the back of this form if necessary.

2552 Route 6
Hawley, PA 18428-9007
(570) 226-4557 ext. 3000
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WALLENPAUPACK AREA SCHOOL DISTRICT

Allergy Information:

Indicate student's allergy, please be specific (for example, peanut, bee sting, penicillin, etc.)

Allergy description:	
Student's reaction:	
Allergy treatment:	
Is medication needed for allergy? At home? ☐ Yes ☐ #No	
At school? ☐ Yes ☐ No	If yes, please complete necessary forms located on the district's Health Services webpage | Health Care Forms section webpage or call 570 226-4557 ext. 3036
Name of Medication:	

Medical Information:

Is your child presently under any medical treatment? ☐ Yes ☐ #No	
If yes, please explain:	
Is medication needed for this condition? At home? ☐ Yes ☐ No	
At school? ☐ Yes ☐ #No	If yes, please complete necessary forms located on the district's Health Services webpage | Health Care Forms section webpage or call 570 226-4557 ext. 3036
Name of Medication:	

List major operations, injuries, or hospitalizations - Give dates:

Is there anything you can tell us about your child that you feel will help the school staff to better understand and work with him/her?

Would you like a conference with the school nurse? ☐ Yes ☐ No

Parent/Guardian Signature Date

*(For official use) - Form review by*_____