



# WALLENPAUPACK AREA SCHOOL DISTRICT

2552 Route 6  
Hawley, PA 18428-7045  
(570) 226-4557 ext. 3000  
Fax: (570) 226-0638

## Health Registration Form

Student's Last Name

Student's First Name

Date of Birth

### Immunization Records:

- Attached
- Medical Exemption Attached
- Religious Exemption Attached

### Allergy Information:

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

<b>Allergy description:</b>	
<b>Student's reaction:</b>	
<b>Allergy treatment:</b>	
Is medication needed for allergy? At home? <input type="checkbox"/> Yes <input type="checkbox"/> No	
At school? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please complete necessary forms located on the district's <a href="#">Health Services</a> webpage   Health Care Forms section webpage or call 570 226-4557 ext. 3036
<b>Name of Medication:</b>	

### Medical Information:

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

Family Physician – Please Print

Phone Number

Family Dentist– Please Print

Phone Number

Last eye examination: Date: \_\_\_\_\_ by Dr. \_\_\_\_\_

Last dental examination: Date: \_\_\_\_\_ by Dr. \_\_\_\_\_

Last medical examination: Date: \_\_\_\_\_ by Dr. \_\_\_\_\_

**Please complete and sign the back of this form.**



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## Medical History

List date of onset for ones that apply to your child. - To be completed by parent

<u>Date</u>	<u>Date</u>	<u>Date</u>
_____ Attention Deficit	_____ Developmental Delay	_____ Skin Disorder
_____ Arthritis	_____ Diabetes	_____ Speech Difficulty
_____ Asthma triggers	_____ Dietary Restrictions	_____ TB Exposure
_____ allergies	_____ Eating Disorder	_____ Thyroid Condition
_____ exercise	_____ Fainting Spells	_____ Vision Deficit
_____ infection	_____ Gastrointestinal Condition	_____ Severe loss
_____ weather	_____ Headaches	_____ eye surgery
_____ Autoimmune Deficiency	_____ Hearing Deficit	_____ glasses/contacts
_____ Bladder Control	_____ Heart Condition	_____ Other (Specify)
_____ Bleeding Disorder/Anemia	_____ High Blood Pressure	_____
_____ Bowel Control	_____ Kidney Condition	_____
_____ Chicken Pox	_____ Lung Condition	_____
_____ vaccine	_____ Malignancy	Use this space, if needed to
_____ disease	_____ Neurological Disorder	elaborate on the above conditions:
_____ Cystic Fibrosis	_____ Neuromuscular Disorder	_____
_____ Color Blindness	_____ Nosebleeds	_____
_____ Connective Tissue	_____ Orthopedic Condition	_____
_____ Disorder	_____ Psychiatric Condition	_____
_____ Dental Condition	_____ Seizures	_____

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 \_\_\_\_\_