



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

- | | | |
|---|---|--|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Dental Condition | <input type="checkbox"/> Orthopedic Condition |
| <input type="checkbox"/> Asthma Triggers | <input type="checkbox"/> Developmental Delay | <input type="checkbox"/> Psychiatric Condition |
| <input type="checkbox"/> allergies | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> exercise | <input type="checkbox"/> Dietary Restrictions | <input type="checkbox"/> Skin Disorder |
| <input type="checkbox"/> infection | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Speech Difficulty |
| <input type="checkbox"/> weather | <input type="checkbox"/> Fainting Spells | <input type="checkbox"/> TB Exposure |
| <input type="checkbox"/> Attention Deficit | <input type="checkbox"/> Gastrointestinal Condition | <input type="checkbox"/> Thyroid Condition |
| <input type="checkbox"/> Autoimmune Deficiency | <input type="checkbox"/> Headaches | <input type="checkbox"/> Vision Deficit |
| <input type="checkbox"/> Bladder Control | <input type="checkbox"/> Hearing Deficit | <input type="checkbox"/> severe loss |
| <input type="checkbox"/> Bleeding Disorder/Anemia | <input type="checkbox"/> Heart Condition | <input type="checkbox"/> eye surgery |
| <input type="checkbox"/> Bowel Control | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> glasses/contacts |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Kidney Condition | <input type="checkbox"/> Other (Specify) |
| <input type="checkbox"/> vaccine | <input type="checkbox"/> Lung Condition | If needed, please use reverse side to elaborate on |
| <input type="checkbox"/> disease | <input type="checkbox"/> Malignancy | the above conditions. |
| <input type="checkbox"/> Color Blindness | <input type="checkbox"/> Neurological Disorder | _____ |
| <input type="checkbox"/> Connective Tissue Disorder | <input type="checkbox"/> Neuromuscular Disorder | _____ |
| <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Nosebleeds | _____ |

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.



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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? <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 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? <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 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 _____