

Kindergarten Registration Procedure

1. Request a registration packet from Central Registrar's office ((570)226-4557 ext. 3000) or download documents from the links below.

The following pdf documents need to be completed and returned.

You may either type the information directly on the form, print and return; or print the forms, handwrite, and return the registration information.

- a. [Parent/Guardian Data Sheet](#) (one per family)
- b. [Student Data Sheet](#) (one per child)
- c. [Health Registration form](#) (one per child)
- d. [Foster Parent form](#) (if appropriate)
- e. [Alternate Income Form](#)

2. Physical Examination / Dental Examination

Pennsylvania requires a physical examination and a dental examination at the time of original entry. Parents have the option of having that exam performed by their own physician/dentist or the school physician/dentist. Private examination forms are due by the first week of October. Also, additional vision, hearing and growth screenings will be completed during the school year.

- a. [Private Physician Examination Report](#)
- b. [Private Dental Examination Report](#)

3. The following documents are informational only - *do not return*.

- a. [Enrollment Documents](#)
- b. [Immunization Requirements](#)
- c. [Bus Regulations](#)

4. Gather documentation - copies of these documents are acceptable.

- a. Birth certificate (must be 5 years of age by August 31), or Baptismal Certificate or Passport
- b. Proof of Residency - the following are acceptable:

- A deed
- A lease
- Current utility bill
- Current credit card bill
- Property tax bill
- Vehicle registration
- Driver's license
- DOT identification card

- c. Immunization Records from physician - [Certificate of Immunization / Immunization Exemption Form](#)
- d. Special Education Records (if applicable)
 - IEP - Individual Education Program
 - ER - Evaluation Report
 - NOREP - Notice of Recommended Educational Placement
 - Psychological / Psychiatric Reports

5. Return documents by mail or drop off as soon as possible.

- a. Mail to:

Wallenpaupack Area District Office
Ms. Miné Gulumoglu, Registrar
2552 Route 6
Hawley, PA 18428

- b. Drop off documents at Wallenpaupack Area District Office.

6. Attend Orientation program

- a. South Elementary - To be announced
- b. North Primary - To be announced

Questions?: Call Ms. Miné Gulumoglu at (570) 226-4557 extension 3000

- or -

email: registrar@wallenpaupack.org.

Forms are in PDF format - Adobe Reader is required. [Click here](#) to download.



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

WALLENPAUPACK AREA SCHOOL DISTRICT

Wallenpaupack Area School District Parent/Guardian Data Sheet

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<i>Last, First</i>	<i>Last, First</i>
<i>Mailing Address</i>	<i>Mailing Address</i>
<i>Town State Zip</i>	<i>Town State Zip</i>
Primary Phone Number: Ĳ	Primary Phone Number:
Secondary Á Ú @ } ^ Number:	Secondary Phone Number:
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***** If guardian is someone other than parent, please complete the following:

Relationship: Ĳ Foster Guardian Ad Litem Agency	
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<i>Last, First</i>	<i>Last, First</i>
<i>Mailing Address</i>	<i>Mailing Address</i>
<i>Town State Zip</i>	<i>Town State Zip</i>
Primary Phone Number: Ĳ	Primary Phone Number:
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The Wallenpaupack Area School District does not discriminate on the basis of race, color, national origin, sex, disability, or age in its programs and activities and provides equal access to the Boy Scouts and other designated youth groups. The following person has been designated to handle inquiries regarding the non-discrimination policies. Keith Gunuskey, Ed.D., Superintendent, 2552 Route. 6, Hawley, PA, 18428. Telephone-570-226-4557.

Wallenpaupack Area School District Parent/Guardian Data Sheet

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Family Information

			Relationship:	Do custody concerns apply to this child?
			Lives at this address Yes No	Yes No
Student's Last Name	Student's First Name	Grade		
			Relationship:	Do custody concerns apply to this child?
			Lives at this address: Yes No	Yes No
Student's Last Name	Student's First Name	Grade		
			Relationship:	Do custody concerns apply to this child?
			Lives at this address: Yes No	Yes No
Student's Last Name	Student's First Name	Grade		

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Custody Information

I am the parent/guardian of the child named above. I am providing this information to the school district for the purpose of ensuring the child's safety and well-being. I understand that this information is confidential and will be used only for the purposes stated above. I agree to provide any additional information requested by the school district.

I am the parent/guardian of the child named above. I am providing this information to the school district for the purpose of ensuring the child's safety and well-being. I understand that this information is confidential and will be used only for the purposes stated above. I agree to provide any additional information requested by the school district.

I am the parent/guardian of the child named above. I am providing this information to the school district for the purpose of ensuring the child's safety and well-being. I understand that this information is confidential and will be used only for the purposes stated above. I agree to provide any additional information requested by the school district.

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Signature of Parent/Guardian: _____ Y^ P[Á

Parent/Guardian Signature

Date:

Wallenpaupack Area School District Student Data Sheet

Student name:		
Last	First	Middle

Military
Is the student's parent/guardian a member of a branch of the United States Armed Forces (Army, Navy, Air Force, Marine Corp, and Coast Guard) including full-time National Guard? <input type="checkbox"/> Yes If yes, please indicate: <input type="checkbox"/> Active Duty <input type="checkbox"/> Veteran <input type="checkbox"/> No

Homeless
Is the student identified as homeless or doubled up? <input type="checkbox"/> Yes If yes, please indicate: <input type="checkbox"/> Shelter; Transitional housing <input type="checkbox"/> Doubled up <input type="checkbox"/> Unsheltered (e.g. cars, parks) <input type="checkbox"/> Hotels/motels <input type="checkbox"/> No

Home Language Survey

The Office of Civil Rights (OCR) requires that school districts/charter schools/full day AVTS identify Limited English Proficient (LEP) students in order to provide appropriate language instructional programs for them. Pennsylvania has selected the Home Language Survey as the method for the identification.

1. What is/was the student's first language?			
2. Does the student speak a language other than English? (Does not include languages learned in school) If yes, specify the language:			
3. What language(s) is/are spoken in your home?			
4. Has the student attended any United States school in any 3 years during his/her lifetime? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If Yes,	Name of School	State	Dates Attended
5. Person completing Home Language Survey, if other than parent/guardian:			
6. If needed, English-speaking contact			
	Name (Last, First)		Phone Number

**The school district/charter school/full day AVTS has the responsibility under the federal law to serve students who are limited English proficient and need English instructional services. Given this responsibility, the school district/charter school /full day AVTS has the right to ask for the information it needs to identify English Language Learners (ELLs). As part of the responsibility to locate and identify ELLs, the school district/charter school /full day AVTS may conduct screenings or ask for related information about students who are already enrolled in the district as well as from students who enroll in the school district/charter school /full day AVTS in the future.*

Parent/Guardian Signature **Date:**

School Official Signature **Date**

For Office Use Only:	<input type="checkbox"/> New Enrollment <input type="checkbox"/> Re-enrollment	<input type="checkbox"/> Proof of Residency <input type="checkbox"/> Birth Certificate
<input type="checkbox"/> Immunization <input type="checkbox"/> Grades to Date <input type="checkbox"/> Contact Information <input type="checkbox"/> 1302 <input type="checkbox"/> 1305 <input type="checkbox"/> Other (describe)		
<input type="checkbox"/> WNPS <input type="checkbox"/> WSES <input type="checkbox"/> WNIS <input type="checkbox"/> WAMS <input type="checkbox"/> WAHS <input type="checkbox"/> WHC		Bus Number: Student ID:



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.



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? <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 _____

Alternate Income Form

Please complete the information listed below and return this form to your child’s school. If you would prefer to complete the form online, please use the QR code to the right. This information is used by the district to determine building and district eligibility for grants, state and federal funding. It is important that our data be as accurate as possible. **This information is confidential and will only be used for state and federal reporting purposes.** Thank you for your assistance!



If you completed this form online, please check here:

Name of Person Completing Form:

Number of people living in the household (students, children, infants, adults, even if not related):

Household income: Circle or highlight the income for the appropriate family size noted in question 2. Report all GROSS income (before taxes) for any household member from work and/or public assistance, child support, alimony, pensions, retirement:

Family Size =1	Family Size=2	Family Size=3
\$0-\$20, 245 per year	\$0-\$27,495 per year	\$0-\$34,645 per year
\$20,246-\$28,953 per year	\$27,495-\$39,128 per year	\$34,646-\$49,303 per year
\$28,953 and up	\$39,129 and up	\$49,304 and up
Family Size=4	Family Size=5	Family Size=6
\$0-\$41,795 per year	\$0-\$48,945 per year	\$0-\$56,095 per year
\$41,796-\$59,478 per year	\$48,946-\$69,653 per year	\$56,096-\$79,828 per year
\$59,479 and up	\$69,654 and up	\$79,829 and up
Family Size=7	Family Size=8 and up	
\$0-\$63,245 per year	\$0-\$70,395 per year	
\$63,246-\$90,003 per year	\$70,396-\$100,178 per year	
\$90,004 and up	\$100,179 and up	

List all WASD students and buildings in this household:

Student Last Name	Student First Name	Building



Bureau of Community Health Systems
Division of School Health

Private or School PHYSICAL EXAMINATION OF SCHOOL AGE STUDENT

PARENT / GUARDIAN / STUDENT:
Complete page one of this form **before**
student's exam. Take completed form to
appointment.

Student's name _____ Today's date _____

Date of birth _____ Age at time of exam _____ Gender: Male Female

Medicines and Allergies: Please list all prescription and over-the-counter medicines and supplements (herbal/nutritional) the student is currently taking:

Does the student have any allergies? No Yes (If yes, list specific allergy and reaction.)

Medicines Pollens Food Stinging Insects

Complete the following section with a check mark in the YES or NO column; circle questions you do not know the answer to.

GENERAL HEALTH: <i>Has the student...</i>	YES	NO
1. Any ongoing medical conditions? If so, please identify: <input type="checkbox"/> Asthma <input type="checkbox"/> Anemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Infection Other _____		
2. Ever stayed more than one night in the hospital?		
3. Ever had surgery?		
4. Ever had a seizure?		
5. Had a history of being born without or is missing a kidney, an eye, a testicle (males), spleen, or any other organ?		
6. Ever become ill while exercising in the heat?		
7. Had frequent muscle cramps when exercising?		
HEAD/NECK/SPINE: <i>Has the student...</i>	YES	NO
8. Had headaches with exercise?		
9. Ever had a head injury or concussion?		
10. Ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
11. Ever had numbness, tingling, or weakness in his/her arms or legs after being hit or falling?		
12. Ever been unable to move arms or legs after being hit or falling?		
13. Noticed or been told he/she has a curved spine or scoliosis?		
14. Had any problem with his/her eyes (vision) or had a history of an eye injury?		
15. Been prescribed glasses or contact lenses?		
HEART/LUNGS: <i>Has the student...</i>	YES	NO
16. Ever used an inhaler or taken asthma medicine?		
17. Ever had the doctor say he/she has a heart problem? If so, check all that apply: <input type="checkbox"/> Heart murmur or heart infection <input type="checkbox"/> High blood pressure <input type="checkbox"/> Kawasaki disease <input type="checkbox"/> High cholesterol <input type="checkbox"/> Other: _____		
18. Been told by the doctor to have a heart test? (For example, ECG/EKG, echocardiogram)?		
19. Had a cough, wheeze, difficulty breathing, shortness of breath or felt lightheaded DURING or AFTER exercise?		
20. Had discomfort, pain, tightness or chest pressure during exercise?		
21. Felt his/her heart race or skip beats during exercise?		
BONE/JOINT: <i>Has the student...</i>	YES	NO
22. Had a broken or fractured bone, stress fracture, or dislocated joint?		
23. Had an injury to a muscle, ligament, or tendon?		
24. Had an injury that required a brace, cast, crutches, or orthotics?		
25. Needed an x-ray, MRI, CT scan, injection, or physical therapy following an injury?		
26. Had joints that become painful, swollen, feel warm, or look red?		
SKIN: <i>Has the student...</i>	YES	NO
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: <i>Has the student...</i>	YES	NO
29. Had groin pain or a painful bulge or hernia in the groin area?		
30. Had a history of urinary tract infections or bedwetting?		
31. FEMALES ONLY: Had a menstrual period? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: At what age was her first menstrual period? _____ How many periods has she had in the last 12 months? _____ Date of last period: _____		
DENTAL:	YES	NO
32. Has the student had any pain or problems with his/her gums or teeth?		
33. Name of student's dentist: _____ Last dental visit: <input type="checkbox"/> less than 1 year <input type="checkbox"/> 1-2 years <input type="checkbox"/> greater than 2 years		
SOCIAL/LEARNING: <i>Has the student...</i>	YES	NO
34. Been told he/she has a learning disability, intellectual or developmental disability, cognitive delay, ADD/ADHD, etc.?		
35. Been bullied or experienced bullying behavior?		
36. Experienced major grief, trauma, or other significant life event?		
37. Exhibited significant changes in behavior, social relationships, grades, eating or sleeping habits; withdrawn from family or friends?		
38. Been worried, sad, upset, or angry much of the time?		
39. Shown a general loss of energy, motivation, interest or enthusiasm?		
40. Had concerns about weight; been trying to gain or lose weight or received a recommendation to gain or lose weight?		
41. Used (or currently uses) tobacco, alcohol, or drugs?		
FAMILY HEALTH:	YES	NO
42. Is there a family history of the following? If so, check all that apply: <input type="checkbox"/> Anemia/blood disorders <input type="checkbox"/> Inherited disease/syndrome <input type="checkbox"/> Asthma/lung problems <input type="checkbox"/> Kidney problems <input type="checkbox"/> Behavioral health issue <input type="checkbox"/> Seizure disorder <input type="checkbox"/> Diabetes <input type="checkbox"/> Sickle cell trait or disease Other _____		
43. Is there a family history of any of the following heart-related problems? If so, check all that apply: <input type="checkbox"/> Brugada syndrome <input type="checkbox"/> QT syndrome <input type="checkbox"/> Cardiomyopathy <input type="checkbox"/> Marfan syndrome <input type="checkbox"/> High blood pressure <input type="checkbox"/> Ventricular tachycardia <input type="checkbox"/> High cholesterol <input type="checkbox"/> Other _____		
44. Has any family member had unexplained fainting, unexplained seizures, or experienced a near drowning?		
45. Has any family member / relative died of heart problems before age 50 or had an unexpected / unexplained sudden death before age 50 (includes drowning, unexplained car accidents, sudden infant death syndrome)?		
QUESTIONS OR CONCERNS	YES	NO
46. Are there any questions or concerns that the student, parent or guardian would like to discuss with the health care provider? (If yes, write them on page 4 of this form.)		

I hereby certify that to the best of my knowledge all of the information is true and complete. I give my consent for an exchange of health information between the school nurse and health care providers.

Signature of parent / guardian / emancipated student _____ Date _____

STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFORMING EXAMINATION: Yes No

Physical exam for grade: K/1 <input type="checkbox"/> 6 <input type="checkbox"/> 11 <input type="checkbox"/> Other <input type="checkbox"/>	CHECK ONE			*ABNORMAL FINDINGS / RECOMMENDATIONS / REFERRALS
	NORMAL	*ABNORMAL	DEFER	
Height: () inches				
Weight: () pounds				
BMI: ()				
BMI-for-Age Percentile: () %				
Pulse: ()				
Blood Pressure: (/)				
Hair/Scalp				
Skin				
Eyes/Vision Corrected <input type="checkbox"/>				
Ears/Hearing				
Nose and Throat				
Teeth and Gingiva				
Lymph Glands				
Heart				
Lungs				
Abdomen				
Genitourinary				
Neuromuscular System				
Extremities				
Spine (Scoliosis)				
Other				

TUBERCULIN TEST	DATE APPLIED	DATE READ	RESULT/FOLLOW-UP

MEDICAL CONDITIONS OR CHRONIC DISEASES WHICH REQUIRE MEDICATION, RESTRICTION OF ACTIVITY, OR WHICH MAY AFFECT EDUCATION

(Additional space on page 4)

Parent/guardian present during exam: Yes No

Physical exam performed at: Personal Health Care Provider's Office School Date of exam _____ 20____

Print name of examiner _____

Print examiner's office address _____ Phone _____

Signature of examiner _____ MD DO PAC CRNP

HEALTH CARE PROVIDERS: *Please photocopy immunization history from student's record – OR – insert information below.*

IMMUNIZATION EXEMPTION(S):

Medical Date Issued: _____ Reason: _____ Date Rescinded: _____
 Medical Date Issued: _____ Reason: _____ Date Rescinded: _____
 Medical Date Issued: _____ Reason: _____ Date Rescinded: _____

NOTE: The parent/guardian must provide a written request to the school for a religious or philosophical exemption.

VACCINE	DOCUMENT: (1) Type of vaccine; (2) Date (month/day/year) for each immunization				
Diphtheria/Tetanus/Pertussis (child) Type: DTaP, DTP or DT	1	2	3	4	5
Diphtheria/Tetanus/Pertussis (adolescent/adult) Type: Tdap or Td	1	2	3	4	5
Polio Type: OPV or IPV	1	2	3	4	5
Hepatitis B (HepB)	1	2	3	4	5
Measles/Mumps/Rubella (MMR)	1	2	3	4	5
Mumps disease diagnosed by physician <input type="checkbox"/>	Date: _____				
Varicella: Vaccine <input type="checkbox"/> Disease <input type="checkbox"/>	1	2	3	4	5
Serology: (Identify Antigen/Date/POS or NEG) i.e. Hep B, Measles, Rubella, Varicella	1	2	3	4	5
Meningococcal Conjugate Vaccine (MCV4)	1	2	3	4	5
Human Papilloma Virus (HPV) Type: HPV2 or HPV4	1	2	3	4	5
Influenza Type: TIV (injected) LAIV (nasal)	1	2	3	4	5
	6	7	8	9	10
	11	12	13	14	15
Haemophilus Influenzae Type b (Hib)	1	2	3	4	5
Pneumococcal Conjugate Vaccine (PCV) Type: 7 or 13	1	2	3	4	5
Hepatitis A (HepA)	1	2	3	4	5
Rotavirus	1	2	3	4	5
Other Vaccines: (Type and Date)					



Type 1 Diabetes Information

This type 1 diabetes information was developed pursuant to the Pennsylvania School Code (24 P.S. § 1414.12) and is for school entities and nonpublic schools to provide to parents and guardians of incoming elementary school students and students entering grade six, beginning with the 2025-2026 School Year.

Type 1 diabetes in children is an autoimmune disease that can be fatal if untreated, and the guidance provided in this information sheet is intended to raise awareness about this disease.

Description

Type 1 diabetes usually develops in children and young adults but can occur at any age

- Type 1 diabetes can appear at any age, but it generally appears at two noticeable peaks. The first peak occurs in children between 4 and 7 years old. The second is in children between 10 and 14 years old ([Mayo Clinic](#)).

Type 1 diabetes affects insulin production

- Normally the body turns the carbohydrates in food into glucose (blood sugar), the basic fuel for the body's cells.
- The pancreas makes insulin, a hormone that moves glucose from the blood into the cells.
- In type 1 diabetes, the body's pancreas stops making insulin, and blood glucose levels rise.
- Over time, glucose can reach dangerously high levels in the blood, which is called hyperglycemia.
- Untreated hyperglycemia can result in diabetic ketoacidosis (DKA), which is a life-threatening complication of diabetes.

Risk Factors Associated with Type 1 Diabetes

It is recommended that children displaying warning signs and symptoms associated with type 1 diabetes described below, should be screened (tested) for the disease by their health care provider.

Risk Factors

Researchers do not completely understand why some people develop type 1 diabetes and others do not. However, having a family history of type 1 diabetes can increase the likelihood of developing type 1 diabetes. Other factors might play a role in developing type 1 diabetes, including environmental triggers such as viruses. Type 1 diabetes is not caused by diet or lifestyle choices.

Warning Signs and Symptoms Associated with Type 1 Diabetes and Diabetic Ketoacidosis

Warning signs and symptoms of type 1 diabetes in children develop quickly, in a few weeks or months, and can be severe. If your child displays the warning signs below, contact your child's

primary health care provider or pediatrician for a consultation to determine if screening your child for type 1 diabetes is appropriate:

- Increased thirst
- Increased urination, including bed-wetting after toilet training
- Increased hunger, even after eating
- Unexplained weight loss
- Feeling very tired
- Blurred vision
- Very dry skin
- Slow healing of sores or cuts
- Moodiness, restlessness, irritability, or behavior changes

DKA is a complication of untreated type 1 diabetes. DKA is a medical emergency. Symptoms include:

- Fruity breath
- Dry/flushed skin
- Nausea
- Vomiting
- Stomach pains
- Trouble breathing
- Confusion

Type 1 Diabetes Treatments

There are no known ways to prevent type 1 diabetes. Once type 1 diabetes develops, medication is the only treatment. If your child is diagnosed with type 1 diabetes, their health care provider will be able to help develop a treatment plan. Your child's health care provider may refer your child to an endocrinologist, a doctor specializing in the endocrine system and its disorders, such as diabetes.

Contact your child's school nurse, school administrator, or health care provider if you have questions.

References

[Centers For Disease Control and Prevention: About Type 1 Diabetes](#)

[Children's Hospital of Philadelphia: Type 1 Diabetes](#)

[Mayo Clinic](#)

[Medline Plus: National Library of Medicine: Type 1 Diabetes](#)