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

Student(s) enrolling:			
County:	☐ Wayne ☐ Pike	Township:	☐ Blooming Grove ☐ Dreher ☐ Greene ☐ Hawley Boro ☐ Lackawaxen ☐ Texas ☐ Palmyra Pike ☐ Palmyra Wayne ☐ Paupack

Primary residence of student: ☐ Yes ☐ No	Primary residence of student: ☐ Yes ☐ No
Access to student records: ☐ Yes ☐ No	Access to student records: ☐ Yes ☐ No
Full Name of Natural Mother:	Full Name of Natural Father:
Last, First	*Last, First*
Mailing Address	*Mailing Address*
Town *State* *Zip*	*Town* *State* *Zip*
Primary Phone Number:	Primary Phone Number:
Secondary Phone Number:	Secondary Phone Number:
Employer Name:	Employer Name:
Work Phone:	Work Phone:
E-mail:	E-mail:
*** * * * * If guardian is someone other than parent, please complete the following:**	
Relationship: ☐ Foster ☐ Guardian Ad Litem ☐ Agency	
Full Name of Guardian:	Full Name of Guardian:
Last, First	*Last, First*
Mailing Address	*Mailing Address*
Town *State* *Zip*	*Town* *State* *Zip*
Primary Phone Number:	Primary Phone Number:
Secondary Phone Number:	Secondary Phone Number:
Employer Name:	Employer Name:
Work Phone:	Work Phone:
E-mail:	E-mail:
Physical Address, if different than mailing address:	

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

Family Information ï Please list all students currently enrolled in the Wallenpaupack Area School District.

			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**		

Custody Information

It is our goal to conform to all ñOrders of the Courtò in regard to the custody of students. It is extremely important that you inform us of any custody agreement of which we should be aware.

Please provide all the necessary information so that we can conform to the ñOrder of the Courtò. It is important that you attach copies of any legal documents that would assist us in performing our duties.

Please return this form and any necessary documents as soon as possible.

☐ There are no contact concerns at this time.

☐ The following contact concerns exist:

Non-custodial parent has limited access to student and/or student records
Non-custodial parent has no access to student and/or student records
Non-custodial parent has no access to student but is permitted access to records
Protection From Abuse (PFA) in effect

Custody Documents Attached: ☐ Yes ☐ No

Parent/Guardian Signature *Date:*

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WALLENPAUPACK AREA SCHOOL DISTRICT

Wallenpaupack Area School District
Student Data Sheet

Student name:				
Last	**First**	**Middle**		**Date of Enrollment**
			Sex: ☐ Male	☐ Female
Birth date: MM/DD/YY	**Age**	**Grade to be Enrolled**		

Birth Country:	☐ US	**If birth country not US, US Entry Date:**	
	Other:	**If birth country not US, School Entry Date:**	
Birth Place: City, State		**If birth state not PA, PA Entry Date:**	
		If applicable, 9th Grade Entry Date:	

Ethnicity

Check all that apply	☐ White non-Hispanic ☐ Hispanic (any race) ☐ Black/African American non-Hispanic ☐ Asian non-Hispanic ☐ American Indian/Alaskan Native ☐ Multi-Racial non-Hispanic ☐ Native Hawaiian or other Pacific Islander non-Hispanic

Emergency Contact Information

In case of emergency, please give names and phone numbers, other than your own to be contacted:	
Name**:**	Phone Number:
	Relationship:
In case of emergency, please give another name and phone number to contact in case of emergency:	
Name:	Phone Number:
	Relationship:

Does the student have an IEP? ☐ Yes ☐ No If yes, please attach a copy.

Does the student have a Service Plan(504)? ☐ Yes ☐ No If yes, please attach a copy.

Does the student have a Gifted IEP? ☐ Yes ☐ No

Does the student receive Title 1 Services? ☐ Yes ☐ No

Did the student attend pre-school? ☐ Yes ☐ No If yes, where?

Does the student participate in the Free/Reduced Lunch Program? ☐ Free ☐ Reduced ☐ Does Not Participate

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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? ☐ Yes If yes, please indicate: ☐ Active Duty ☐ Veteran ☐ No

Homeless
Is the student identified as homeless or doubled up? ☐ Yes If yes, please indicate: ☐ Shelter; Transitional housing ☐ Doubled up ☐ Unsheltered (e.g. cars, parks) ☐ Hotels/motels ☐ 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? ☐ Yes ☐ 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:	☐ New Enrollment ☐ Re-enrollment	☐ Proof of Residency ☐ Birth Certificate
☐ Immunization ☐ Grades to Date ☐ Contact Information ☐ 1302 ☐ 1305 ☐ Other (describe)		
☐ WNPS ☐ WSES ☐ WNIS ☐ WAMS ☐ WAHS ☐WHC	Bus Number:	Student ID:

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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.

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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*_____

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WALLENPAUPACK AREA SCHOOL DISTRICT

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Keith E. Gunuskey, Ed.D.
Superintendent

Jay Starnes, Ed.D.
Assistant Superintendent

Kerriann Horan
Business Administrator

Jillian Klocko
Board Secretary

Dear Parent/Guardian,

Schools receive certain federal and state funding (learning assistance programs, teacher incentives, etc.) based on the number of children from households that are at certain income levels or receive specific benefits. Completing this survey will ensure that our district receives the funding we are entitled to, enabling our children to continue receiving services funded by these federal and state programs.

Please be aware that we will only submit these mandatory district statistics to the Pennsylvania Department of Education for use in determining our school budget.

This vital form is required to be completed and returned for every student in the district. Please contact your building principal if you have any questions,

Best Regards,

Dr. Keith E. Gunuskey, Superintendent

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2026-2027 Subsidies Survey

Student Name:_____

Does your student qualify for any of the following (check all that apply):

- ☐ The above student does not qualify for anything listed below
- ☐ Medicaid
- ☐ SNAP
- ☐ TANF
- ☐ Reduced-Price Lunch
- ☐ Free Lunch
- ☐ Total Household Income (see below)

  If your total household income is equal to or less than the amount listed for your household size, check this line. Amounts effective from 7/1/2026-6/30/2027.

	How Often Payment is Received				
Household Size	**Annual**	**Monthly**	**Twice Per Month**	**Every Two Weeks**	**Weekly**
1	$29,526	$2,461	$1,231	$1,136	$568
2	$40,034	$3,337	$1,669	$1,540	$770
3	$50,542	$4,212	$2,106	$1,944	$972
4	$61,050	$5,088	$2,544	$2,349	$1,175
5	$71,558	$5,964	$2,982	$2,753	$1,377
6	$82,066	$6,839	$3,420	$3,157	$1,579
7	$92,574	$7,715	$3,858	$3,561	$1,781
8	$103,082	$8,591	$4,296	$3,965	$1,983
Each Additional Member Add	$10,508	$876	$438	$405	$203

Household is defined as all people, including parent(s), children, grandparents and all people related or unrelated who live in your home and share living expenses. If you're applying for a household with a foster child, you may include the foster child I the total size.

Household Income is any taxable income each household member received before taxes. This includes wages, social security, pension, unemployment, welfare, child support, alimony and any other cash income. If including a foster child as part of the household, you must also include the foster child's personal income. Do not count foster payments as income.

I certify that all information on this application is true and that all income is reported, I understand that the school will get state and federal funds based on the information I give. I understand my child's poverty status may be shared with programs/agencies as allowed by law.

Signature: _____

Print Name: _____ **Date:** _____

pennsylvania
DEPARTMENT OF HEALTH

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: ***Has the student…***	**YES**	**NO**
1. Any ongoing medical conditions? If so, please identify: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ 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: ***Has the student…***	**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: ***Has the student...***	**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: ☐ Heart murmur or heart infection ☐ High blood pressure ☐ Kawasaki disease ☐ High cholesterol ☐ 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: ***Has the student...***	**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: ***Has the student…***	**YES**	**NO**
27. Had any rashes, pressure sores, or other skin problems?		
28. Ever had herpes or a MRSA skin infection?		

GENITOURINARY: ***Has the student…***	**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? ☐ Yes ☐ 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: ☐ less than 1 year ☐ 1-2 years ☐ greater than 2 years		
SOCIAL/LEARNING: ***Has the student…***	**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: ☐ Anemia/blood disorders ☐ Inherited disease/syndrome ☐ Asthma/lung problems ☐ Kidney problems ☐ Behavioral health issue ☐ Seizure disorder ☐ Diabetes ☐ 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: ☐ Brugada syndrome ☐ QT syndrome ☐ Cardiomyopathy ☐ Marfan syndrome ☐ High blood pressure ☐ Ventricular tachycardia ☐ High cholesterol ☐ 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_____

Adapted in part from the ***Pre-participation Physical Evaluation History Form***; ©2010 American Academy of Family Physicians, American Academy of Pediatrics, American College of Sports Medicine, American Medical Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and American Osteopathic Academy of Sports Medicine.

STUDENT'S HEALTH HISTORY (page 1 of this form) REVIEWED PRIOR TO PERFOMING EXAMINATION: Yes ☐ No ☐				
Physical exam for grade: K/1 ☐ 6 ☐ 11 ☐ Other ☐	**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 ☐				
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 ☐	Date:_____				
Varicella: Vaccine ☐ Disease ☐	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)					

 ADDITIONAL COMMENTS (PARENT / GUARDIAN / STUDENT / HEALTH CARE PROVIDER)

H514.027

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF HEALTH

PRIVATE DENTIST REPORT
OF DENTAL EXAMINATION OF A PUPIL OF SCHOOL AGE

NAME OF SCHOOL_____ DATE _____ 20 ___

NAME OF CHILD	AGE	SEX	GRADE	SECTION/ROOM
_____ Last First Middle		☐ M ☐ F		

ADDRESS

_____
No. and Street City or Post Office Borough or Township County State Zip

REPORT OF EXAMINATION

TOOTH CHART

		RIGHT								LEFT								
UPPER		1	2	3	4 A	5 B	6 C	7 D	8 E	9 F	10 G	11 H	12 I	13 J	14	15	16	Upper
LOWER		32	31	30	29 T	28 S	27 R	26 Q	25 P	24 O	23 N	22 M	21 L	20 K	19	18	17	Lower
	UPPER																	Upper
	LOWER																	Lower

Is The Child Under Treatment Yes ☐ No ☐

Treatment Completed Yes ☐ No ☐

_____
Date of Dental Examination

_____ _____
Signature of Dental Examiner Print Name of Dental Examiner

_____
Address

Pennsylvania
Department of Health

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