DISTRICT OFFICE
1970c Easton Turnpike
Lake Ariel, Pennsylvania 18436

WESTERN WAYNE
SCHOOL DISTRICT

Pupil Health Information

Child's Name _____ Phone _____
Last First Middle

Birth Certificate must be presented at registration.
Pennsylvania Law requires the following immunizations for entry into school.
Please provide written proof of immunization from your doctor or clinic.

- 4 Doses of Diphtheria and Tetanus (1 dose after age 4)
- 3 Doses of Polio
- 2 Doses of MMR (Measles, Mumps, Rubella)
- 3 Doses of Hepatitis B
- 2 Doses Varicella or date of Chickenpox disease

IN ADDITION for Middle/High School:

- 1 dose of Meningitis Vaccine and 1 dose of Tdap (Prior to entering 7th grade)
- 1 dose of meningitis (Prior to entering 12th grade)

A written statement from your physician or religious leader is required for medical or religious exemption to immunization laws.

Date of Birth _____/_____/_____ Place of Birth _____

Mother's Name _____ ☐Natural ☐Divorced ☐Separated ☐Step or Foster
Last First Maiden

Father's Name _____ ☐Natural ☐ Divorced ☐Separated ☐Step or Foster
Last First

Address _____ City _____State ____ Zip _____

Person with whom child lives if other than parents _____

List names of other children in the family/household:

Name	Date of Birth	School
	/ /	
	/ /	
	/ /	
	/ /	

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Doctor's Name _____

HEALTH HISTORY

PREGNANCY AND BIRTH

☐Yes ☐No Was the pregnancy and delivery normal?
☐Yes ☐No Was the baby born on time?
☐Yes ☐No Did the baby have difficulties during or after birth?
Baby's Birth Weight _____

Please indicate if your child has or had any of the following. If so, please explain in the blank provided.

☐Yes ☐No Allergies to food, medication, plants, insects, other _____
Treatment for allergy _____

☐Yes ☐No Asthma/Breathing Problems _____

☐Yes ☐No Diabetes _____

☐Yes ☐No Chicken Pox (*Indicate year of Chickenpox disease*) _____

☐Yes ☐No Measles _____

☐Yes ☐No Rashes or skin problems _____

☐Yes ☐No Seizures/Convulsions (what type?) _____

☐Yes ☐No Heart Problems _____

☐Yes ☐No Stomach/Digestive Problems _____

☐Yes ☐No Urinary Tract Problems _____

☐Yes ☐No Operations (what type and at what age?) _____

☐Yes ☐No Serious illnesses _____

☐Yes ☐No Serious injuries, Accidents, Broken Bones _____

☐Yes ☐No Other Hospitalizations _____

☐Yes ☐No Ear/Hearing Problems, Hearing Aides _____

☐Yes ☐No Eye/Vision Problems, Glasses or Contacts _____

☐Yes ☐No Emotional or Adjustment Difficulties _____

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☐Yes ☐No Behavior/Discipline Problems _____

☐Yes ☐No Developmental Difficulties or Delays (walking, talking, etc.) _____

☐Yes ☐No Is your child under a doctor's care now? Why? _____

☐Yes ☐No Does your child take medication? _____

1. Name of medicine _____ Reason _____

2. Name of medicine _____ Reason _____

☐Yes ☐No Is anyone in the household seriously ill?

☐Yes ☐No Do you have any concerns regarding your child's health or growth?

_____

_____

Parent/Guardian Signature _____ Date _____

If transferring from another school:

Name of School _____

City, State _____

Phone # _____

Fax # _____