PHYSICIAN'S MEDICAL RECORD | **School Entrance Medical Record**

To be completed by your physician and returned to Bethel Christian Academy

Child's Name ________________________________ Birthdate ________________ Grade ____

Address ________________________________ Telephone No. ____________________

Examination

Height ______________ Weight __________ Eyes__________ Ears__________

Vision ______________ Hearing Test: Type __________ R_____ L_____

Nose ______________ Throat ____________ Mouth ______________

Teeth ______________ Is dental work indicated? ___YES ___NO

If so, are plans being made? ____YES ___NO

General Condition ________________ Posture ____________________ Skin ______________

Orthopedic ______________________ Neck __________________ Heart ______________

Nervous System ________________ Abdomen __________________ Genitalia ____________

Urinalysis ______________________ Lungs ____________________ Hernia ______________

Remarks and Recommendations ____

____

Health Protective Measures

Dates Received:

*DTP 1. ________ 2. ________ 3. ________ 4. ________ 5. ________

*Polio 1. ________ 2. ________ 3. ________ 4. ________ 5. ________

*MMR 1. ________ 2. ________
(Measles, Mumps, Rubella)

*HIB 1. ________ 2. ________ 3. ________ 4. ________

*Hepatitis B 1. ________ 2. ________ 3. ________

*Varicella 1. ________ 2. ________

*Tdap 1. ________ (required for 7th grade students)

Other (specify type and date) ____

***Above immunizations are required for school entrance by Ohio Revised Code.**

________________________ ________________________ __________
Physician's Name Physician's Signature Date

Please mail or fax to:
Bethel Christian Academy, 12901 W. Pleasant Valley Rd., Parma, Ohio 44130
Phone: 440-842-8575 or Fax: 440-842-3226