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. _____

Date of 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 A 1. _____ 2. _____

*Hepatitis B 1. _____ 2. _____ 3. _____

*Prevnar 1. _____ 2. _____ 3. _____ 4. _____

*Varicella 1. _____ 2. _____

*Annual Flu Vaccine 1. _____

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