

# PHYSICAL EXAMINATION FORM

Bethlehem Christian Academy  
27250 Emery Road - Orange Village, Ohio 44128  
(216) 292-4685

CHILD'S NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ BLOOD PRESSURE \_\_\_\_\_

EXAMINATION: DATE \_\_\_\_\_ NORMAL \_\_\_\_\_ ABNORMAL \_\_\_\_\_

Problems or abnormalities:

DEVELOPMENT: Normal: Yes \_\_\_\_\_ No \_\_\_\_\_  
Comments:

HEARING - Type of Test \_\_\_\_\_  
Date:

Comments:

VISION - Type of Test \_\_\_\_\_  
Date:

Acuity: R \_\_\_\_\_ L \_\_\_\_\_

Strabismus: Yes \_\_\_\_\_ No \_\_\_\_\_

Comments:

IMMUNIZATION DATES:  
DPT \_\_\_\_\_ Td \_\_\_\_\_  
Oral OPV/IPV \_\_\_\_\_  
Hib \_\_\_\_\_  
MMR \_\_\_\_\_  
Hepatitis B \_\_\_\_\_  
Varicella (mandatory for Kndg beginning 06-07) \_\_\_\_\_  
Others \_\_\_\_\_

TESTS:	Date	Result
Tuberculin	_____	_____
Hb/Hct	_____	_____
Sickle Cell	_____	_____
Lead	_____	_____
Urinalysis	_____	_____

ALLERGIES:

MEDICATIONS:

This student has completed the immunizations required by the state Yes  No  and in my opinion is free of any communicable disease and may be admitted to school Yes  No .

Physician Signature \_\_\_\_\_ Date \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_