Bethesda Christian Academy

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Student Medical Form

Name of Student: _____ Birth Date:_____

Name of Parent or Guardian: _____

Address: _____ City:_____ State:_____ Zip:_____

A. MEDICAL HISTORY (To be completed by the parent)

1. Is your child allergic to anything? ❑ Yes ❑ No If yes, what? _____
_____
2. Is your child under a doctor's care? ❑ Yes ❑ No If yes, why? _____
_____
3. Any previous hospitalizations or operations? ❑ Yes ❑ No If yes, what? _____
_____
4. Is your child on any continuous medications? ❑ Yes ❑ No If yes, what? _____
_____
5. Any history of diseases or recurrent illnesses? ❑ Yes ❑ No If yes, what? (diabetes, convulsions, heart trouble, etc.) _____
_____
6. Does your child have any physical disabilities? ❑ Yes ❑ No If yes, please describe: _____
_____
7. Does your child have any mental disabilities? ❑ Yes ❑ No If yes, please describe: _____
_____

B. PHYSICAL EXAMINATION (To be completed by a licensed physician, certified nurse practitioner, or public health nurse)

Height _____% Weight _____% Head _____ Eyes _____ Ears _____ Nose _____ Teeth _____
Throat _____ Neck _____ Heart _____ Chest _____ Abd/GU _____ Ext _____ Skin _____
Neurological System _____ Should activities be limited? ❑ Yes ❑ No If yes, explain: _____
_____
Results of Tuberculin Test, if given: Type _____ Date_____; Normal _____ Abnormal _____
Any other recommendations? _____
Examiner's signature/title _____ Date_____ Phone_____

C. IMMUNIZATION HISTORY (The school or health official must enter the date immunization was received in the space below or attach a copy of the immunization record.)

Type of Vaccine	#1	#2	#3	#4	#5
*DPT or DT (circle one)					
*Polio					
**Hib					
*MMR (combined doses)					
***Measles (two doses)					
Mumps (single dose)					
Rubella (single dose)					
***Hep. B (three doses)					
Other					

*Required by State Law **Required by State Law if born on or after 10-1-91
***Required by State Law if born on or after 7-1-94