Westside Christian Academy
School Entrance Medical Record

Student's Name:______________________________ Birth Date: ______________ Sex: M F

Address:____
Street City/State/Zip

Teacher: ____ Grade:____________________

Please have your child's physician complete
the following examination information

Date of Examination:______________________ Height:______________ Weight:__________

Overall Health Condition:____

Eyes:_______Color Perception:_______ Wears Glasses:_______Vision: R.20/____;L.20/______

Ears:______________ Auditory Acuity Type: ______________ R.__________ L.___________

Referred to ear or eye specialist? Yes No

Skin/Scalp:______________________________________

Nose:_________________________ Throat:____________________ Tonsils:______________

Mouth:________________________ Teeth:____________________ Speech:______________

Is dental work indicated? Yes No
If so, are plans being made? Yes No

Orthopedic (include scoliosis screening):____

Glands: Lymphatic:_________________ Thyroid:______________ Nervous System:__________

Heart:_____________________ Lungs:____________________ Abdomen:_________________

Hernia:____________________ Urinalysis:________________

Handicaps/Disabilities:____

Emotional/Behavior Problems:____

Seizures? Yes No If yes, describe:____

On Medication? Yes No If yes, describe:____

IMMUNIZATION RECORD

DTP: 1st ________________ 2nd________________ 3rd________________ Boosters ___________________

Polio Vaccine Dates: 1st___________ 2nd___________ 3rd___________ 4th____________ 5th ___________

Measles:______________________ Rebella:______________________ Mumps:_______________________

Month/Day/Year Received after first birthday | Month/Day/Year Received after first birthday | Month/Day/Year Received after first birthday

Hepatitis B: 1st _____________ 2nd ____________ 3rd ____________ 4th _________________

Other immunizations:____

Tuberculin Test: Type ___________________________________ Date_______________________________

Positive Negative

____ _________________________

Physician's Signature Date

Physician's Stamp:

Physician's Name:____ Phone:__________________

Group Name (if applicable):____

Address:____

Street City/State/Zip

To the Physician:

Please mail this form directly to:

Westside Christian Academy
23096 Center Ridge Rd.
Westlake, OH 44145
440-331-1300
Fax – 440-331-1301