Berean Christian Junior Academy

401 Hamilton E. Holmes Drive NW
Atlanta, GA 30318
(404) 799-0337 Fax (470) 225-7250

Health Inventory 1 of 4: Physical Exam

(To be filled out by the Applicant's Doctor)

This form or a copy of your child's history and physical, along with a copy of his/her immunization record must be submitted to BCJA **before** your child will be admitted to any classes.

Student's Full Name—Last:_____ First:_____ Middle:_____

Date of Birth—Month:_____ Day:_____ Year:_____

Healthcare Provider's Name:_____ Signature:_____

Healthcare Provider's Phone Number:_____ Evaluation Date:_____

HEALTH EVALUATION

1. Does this child have a health condition(s) which may require **EMERGENCY ACTION** while he/she is at school (e.g., seizures, asthma, insect sting allergy, bleeding problem, diabetes, heart problem)? ☐ Yes ☐ No If yes, please describe:_____

2. Is there any evidence for **concern** in the areas listed below?

Health Area	Yes	No	Comments (please complete if "Yes")
Vision			
Hearing			
Dental			
Speech / Language			
Physical Illness or Impairment			
Mental, Emotional Problems			
Development			
Allergies			
Nutrition			

3. Is the student on **long-term medication**? Does the child need an epi-pen, asthma inhaler or any other medication kept on hand at school ☐ Yes ☐ No If yes, please explain:_____

_____

4. Should there be any **restriction of physical activity** in school? ☐ Yes ☐ No. If yes, please specify nature and duration. _____

BCJA Health Inventory 2 of 4: Physical Exam Continued

(To Be Filled Out By the Applicant's Doctor)

5. Is child subject to condition that may cause classroom emergencies, such as diabetes, fainting, **allergies**, asthma, etc? ☐ Yes ☐ No

Explain_____

6. Have there been any illnesses, accidents, operations or defects that limit this child's **participation in classroom activities, PE or intramural and varsity sports?** ☐ Yes ☐ No

Explain_____

7. Are there any **vision or hearing** differences for which the school could help compensate by seating or other action? ☐ Yes ☐ No

Explain_____

8. Are there any **other defects** for which the school could help by seating or other action? ☐ Yes ☐ No

Explain_____

9. Is there need for **dental care?** ☐ Yes ☐ No

Explain_____

10. Is there any reason for which this child should remain under a **physician's periodic observation?** ☐ Yes ☐ No

Explain_____

Does this child need special **emotional/social/psychological** support? ☐ Yes ☐ No

Explain_____

12. Physician's recommendations to school:_____

_____

*Signature of Physician:*_____ *Date*_____

*Name of Doctor's Office or Clinic*_____ *Phone No.*_____

*Address*_____

BCJA Health Inventory 3 of 4: Immunizations

(To Be Filled Out By the Applicant's Doctor)

Name:_____ Grade_____

Address:_____

Date of Birth:_____ Age: _____

Name of School:_____

Name of Doctor:_____ Date of Examination: _____

IMMUNIZATION STATUS

Give the date of each immunization or date of blood test to prove immunity.

	1st Dose	2nd Dose	3rd Dose	4th Dose	Additional doses needed at this time?	
DTaP, DTP, DT Circle Choice				4 doses of diphtheria, tetanus, & pertussis or combined/ 3 doses for children over 7	Yes	No
Td				3 doses required for pupils 7 or older	Yes	No
Polio				3 doses for pupils less than 18	Yes	No
Measles			2 doses of 5 virus vaccine by first birthday	Proof of Immunity by positive blood test acceptable	Yes	No
Rubella		1 dose of 5 virus vaccine	Vaccine must have been given on or after first birthday	Proof of Immunity by positive blood test acceptable	Yes	No
Mumps		1 dose of 5 virus vaccine	Vaccine must have been given on or after first birthday	Proof of Immunity by positive blood test acceptable	Yes	No
Haemophilus Influenza Type B, HIB		1 dose of 5 virus vaccine	Vaccine must have been given on or after first birthday	Proof of Immunity by positive blood test acceptable	Yes	No
Hepatitis B			3 doses required for pupils 5 or older	Proof of immunity by blood test acceptable	Yes	No
Chickenpox		1 dose of 5 virus vaccine	Vaccine must have been given on or after first birthday	Proof of Immunity by positive blood test acceptable/ documented chicken pox disease	Yes	No
Pneumococcal (Prevnar/PCV7		1 dose	Vaccine must be given to students less than 5 yrs to be enrolled in Preschool		Yes	No

Are there medical reasons for this child to be exempt from any of the above immunizations? ☐ Yes ☐ No

If "Yes", explain: _____

Results of **Tuberculin Test**: ☐ Positive ☐ Negative Type of Test:_____

Explain any Positive Results:_____

_____

BCJA Health Inventory 4 of 4:
Continuing Consent Allergy Form

For the health and safety of your child, it is necessary that we have detailed information regarding his/her allergies. Please take the time to fill out the information below.

Child's name _____ Grade _____

Allergy	Severity			Please describe possible reactions	Recommended Treatment
	Mild	Mod	Severe		

Please note: All medications must be turned in to your child's teacher. Students are ***NEVER*** *to administer medications themselves without the supervision of the teacher.*

Parents will always be notified about any incidents that may occur during the school day. Under what conditions would you like to be notified immediately?

Under what conditions should we seek immediate medical attention? (Note: we will always contact you in an emergency.)

Print Name	Best number to reach you	Alternate #

Second Emergency Contact	Phone #	Alternate #

☐ **My child, _____ does not have any allergies.**

Parent Signature _____ Date _____