

**KOINONIA ACADEMY MEDICAL HISTORY AND PHYSICAL EXAMINATION**

Student's Name \_\_\_\_\_ Birth Date \_\_\_\_\_  
Address \_\_\_\_\_ Telephone # \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

**History of: (Check if "yes" and explain on back)**

- |                                                    |                                          |
|----------------------------------------------------|------------------------------------------|
| Allergies _____ <b>-If severe, submit protocol</b> | Congenital Problem _____                 |
| Asthma _____ <b>-Submit protocol</b>               | Rheumatic Fever _____                    |
| Diabetes _____ <b>-Submit protocol</b>             | Serious Injury _____                     |
| Drug Sensitivities _____                           | Serious Illness _____                    |
| Epilepsy or Convulsions _____                      | Surgery _____                            |
| Dental Concern (caps, braces, etc.) _____          | Speech Problem _____                     |
| Fainting _____                                     | Vision Problem _____                     |
| Head Injury _____                                  | Other Medical problem _____              |
| Heart Disease _____                                | Significant family medical problem _____ |
| Lyme Disease _____                                 |                                          |

**Physical Examination:**

- |                    |                        |
|--------------------|------------------------|
| Ears _____         | Hernia _____           |
| Eyes _____         | Genito-Urinary _____   |
| Lymph Glands _____ | Orthopedic:            |
| Thyroid _____      | -Structural _____      |
| Nose _____         | -Posture _____         |
| Throat _____       | -Scoliosis _____       |
| Teeth-Mouth _____  | -Feet _____            |
| Heart _____        | Skin (non Comm.) _____ |
| Lungs _____        | Nutrition _____        |
| Abdomen _____      | Nervous System _____   |

General Condition: \_\_\_\_\_ Recommendations: \_\_\_\_\_  
This student is able to participate in all usual school activities, including Physical Education, with the following exceptions: \_\_\_\_\_

Date of Examination: \_\_\_\_\_ Examining Physician: \_\_\_\_\_  
Date of last TD Booster: \_\_\_\_\_ Other Recent Immunizations \_\_\_\_\_

Please use reverse side for additional information which you feel may be of value to the school.

NOTE: If this student is taking any regular medication, please list. If **any** medication needs to be administered **at school**, please attach a prescription and directions for medication. This includes over the counter (ex. Tylenol), emergency (ex. for acute allergy or asthma), as well as any prescription drugs needed by this student.

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**FOR NEW STUDENTS ONLY:**

PLEASE INDICATE COMPLETE DATES WHEN THE FOLLOWING IMMUNIZATIONS WERE GIVEN.  
**ALL ARE REQUIRED BY NEW JERSEY STATE LAW**

DPT {4 doses + Booster} \_\_\_\_\_,  
{Final dose on or after 4th birthday}  
POLIO {4 doses} \_\_\_\_\_,  
{Final dose on or after 4th birthday}  
MMR: #1 dose after 15 months of age \_\_\_\_\_ Dose #2 \_\_\_\_\_ 2nd Dose required if born after 1/90  
Hepatitis B \_\_\_\_\_, Hepatitis A \_\_\_\_\_

\*Varicella (Chicken Pox)\* - Date of disease or Immunization \_\_\_\_\_ \*Required if born after 1/1/98

DPT Booster for students entering Grade 6 \_\_\_\_\_

Meningococcal Vaccine for students entering Grade 6 \_\_\_\_\_