Cliffside Park Public Schools

A physical examination MUST have been performed within 365 days of entrance into school

Name:_____ **School:**_____ **D.O.B:**_____

Address:_____**Grade:**_____

VACCINE TYPE	1st Dose Mo/Day/Yr	2nd Dose Mo/Day/Yr	3rd Dose Mo/Day/Yr	4th Dose Mo/Day/ Yr	5th Dose Mo/Day/Yr	6th Dose Mo/Day/Yr
DTP, DT, DTaP, Tdap, Td Or Tdap (indicate Type						
Polio (Indicate OPV or IPV)						
M M R						
Measles (Live)						
Rubella						
Mumps						
HbPV/HIB						
Hepatitis B						
Varicella			Gardasil			
Pneumococcal Conjugate						
Meningococcal			Flu Vaccine			
Hepatitis A			**Mantoux**		Result	

(only if indicated)

Physician's Examination: Code: No Defect = 0 Defects = X Under Treatment = T

Eyes	Hearing	Height	**Health History Dates**	
Ears	Throat	Weight	Asthma	Diabetes
Nose	Lungs	Blood Pressure	Allergies	Surgeries
Heart	Genitalia	Abdomen	Chicken Pox	Rheumatic Fever
Skin	Scoliosis	Nutrition	German Measles	Convulsions
Hernia	Dental	Nervous System	Tuberculosis	Epilepsy
Coordination	Vision	Feet	Measles	Emotional Problems
		Lymph Nodes	Mumps	Serious Injury

General Condition:_____

_____

☐ **May** ☐ **May not** – participate in all physical activities and athletic competition

The above mentioned student ☐**is** ☐ **is not** on medication - Name of medication: _____

Reason for medication: _____ Other medical concerns: _____

_____

Physician's Name:	**Physician's Signature:**
Address:	**Date of Examination:**
Phone: **Fax:**	**Email:**

(Physician's Stamp Required)