Cliffside Park Public Schools

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

Mo/Day/Yr Mo/Day	Name:Address:		School:				D.O.B: Grade:		
Mo/Day/Yr Mo/Day									
DTP, DT, DTaP, Tdap, Td Or Tdap (indicate Type Polio (Indicate OPV or IPV) M M R Measles (Live) Mumps HbPV/HIB Hepatitis B Varicella Pneumococcal Conjugate Meningococcal Hepatitis A Mantoux Conly if indicated) Physician's Examination: Code: No Defect = 0 Defects = X Under Treatment = T Eyes Hearing Hearing Height Health History Dates Heart Genitalia Abdomen Chicken Pox Rheumatic Fever Skin Scoliosis Nutrition German Measles Convulsions Hernia Dental Nervous System Tuberculosis Epilepsy Coordination Vision Feet Measles Emotional Problem General Condition: General Condition: Physician's Name: Address: Physician's Signature: Address:								6 th Dose Mo/Day/Yı	
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	Address:					Date of Examination:			
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(Physician's Stamp Required)