Cliffside Park Public Schools

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

Name: ____________________________ School: _______________ Date of birth: ___________

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(IndcateOPVor IPV)						
M M R						
Measles (Live)						
Rubella						
Mumps						
HbPV/HIB						
Hepatitis B						
Varicella			Gardasil			
PneumococcalConjugate						
Meningococcal			Flu Vaccine			
Hepatitis A			Mantoux if indicated		Result	

Physician's Examination…

Code: No Defect = 0 Defects = X Under Treatment = T

Eyes: _______________
Ears: _______________
Nose: _______________
Heart: _______________
Skin: _______________
Hernia: _______________
Coordination: _________
Vision: _______________

Hearing: _____________
Throat: _____________
Lungs: _____________
Allergies: _____________
Genitalia: _____________
Scoliosis: _____________
Teeth: _____________

Height: ____________________
Weight: ____________________
Lymph Nodes: ______________
Abdomen: __________________
Nutrition: __________________
Nervous System: ____________
Feet: ______________________
Blood Pres.: ________________

Health History – Dates

Asthma: ____________
Chicken Pox: ________
German Measles: ___
Tuberculosis: ________
Serious Injury ________

Measles: ___________
Mumps: ____________
Diabetes: ____________
Operations: __________

Rheumatic Fever: _________
Convulsions: ______________
Epilepsy: __________________
Emotional Problems: ________

1. General Condition: ____

   ____

2. May ______ may not ______ participate in all physical activities and athletic competition.

3. The above named student is ______ is not ________ on medication.

   Name of medication: _________________________Reason for medication: ______________________________

   Other medical conditions: ____

   ____

Name: ______________________________
Address: ____________________________
Phone: ______________________________

Physician's Signature: ______________________
Date of Examination:________________________