

MEDICAL Information

A PHYSICAL EXAMINATION FORM COMPLETED BY THE CHILD'S PHYSICIAN DATED AFTER 9/1/18

Physical examination forms must be presented at the time of registration.

Proof of immunizations, **as required by State Law**. This must include the month, day and year in which the immunizations were administered and have the physician's signature or stamp. These documents will be reviewed by our school nurse during registration.

Kindergarten Medical

- A. Diphtheria-Whooping Cough-Tetanus (DPT) – Four doses with last one administered on or after the fourth birthday or any five doses.
- B. Polio – Three doses with last one administered on or after the fourth birthday or any four doses.
- C. Measles, Mumps and Rubella (MMR) – Two doses with one administered on or after the first birthday or laboratory evidence of immunity.
- D. Varicella Vaccine (Chicken Pox) – One dose administered on or after the first birthday or laboratory evidence of immunity.
- E. Hepatitis B – Three doses.

Please submit any other information concerning your child's history of illness, which may help us to better understand your child's needs.

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	1 st Dose Mo/Day/Yr	2 nd Dose Mo/Day/Yr	3 rd Dose Mo/Day/Yr	4 th Dose Mo/Day/Yr	5 th Dose Mo/Day/Yr	6 th 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 Only		Result	

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

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

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: _____