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 Only		Result	

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	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:**

Updated: January 2018