

**Clifton Public Schools  
Clifton, NJ  
Physical Examination Report**

Name \_\_\_\_\_  
Birthdate \_\_\_\_\_  
Grade \_\_\_\_\_ Room \_\_\_\_\_  
Height \_\_\_\_\_ Weight \_\_\_\_\_  
Blood Pressure \_\_\_\_\_  
Nutrition \_\_\_\_\_  
Posture \_\_\_\_\_  
Skin \_\_\_\_\_  
Eyes/Lids \_\_\_\_\_  
Vision Acuity R \_\_\_\_\_ L \_\_\_\_\_  
Vision with Glasses R \_\_\_\_\_ L \_\_\_\_\_  
Hearing R \_\_\_\_\_ L \_\_\_\_\_  
Nose \_\_\_\_\_  
Throat \_\_\_\_\_  
Lymph Nodes \_\_\_\_\_  
Heart \_\_\_\_\_  
Lungs \_\_\_\_\_  
Spine/Joints \_\_\_\_\_  
Scoliosis \_\_\_\_\_  
Feet \_\_\_\_\_  
Nervous System \_\_\_\_\_  
Deformities \_\_\_\_\_  
Tanner Scale \_\_\_\_\_

**Lead Level**

Date of Last Test \_\_\_\_\_  
Highest Level \_\_\_\_\_

DATE OF PHYSICAL EXAMINATION

\_\_\_\_\_  
Telephone Number  
\_\_\_\_\_

**Immunizations**

DPT/DaPT (Circle Type)  
#1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_  
#4 \_\_\_\_\_ #5 \_\_\_\_\_ Tdap \_\_\_\_\_  
OPV/IPV (Circle Type)  
#1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_  
#4 \_\_\_\_\_ #5 \_\_\_\_\_  
MMR #1 \_\_\_\_\_ #2 \_\_\_\_\_  
HIB #1 \_\_\_\_\_ #2 \_\_\_\_\_  
#3 \_\_\_\_\_ #4 \_\_\_\_\_  
Hepatitis B #1 \_\_\_\_\_ #2 \_\_\_\_\_  
#3 \_\_\_\_\_  
Hepatitis A #1 \_\_\_\_\_ #2 \_\_\_\_\_  
Varivax #1 \_\_\_\_\_ #2 \_\_\_\_\_  
Pevnar #1 \_\_\_\_\_ #2 \_\_\_\_\_  
#3 \_\_\_\_\_ #4 \_\_\_\_\_  
Menactra \_\_\_\_\_  
Gardasil #1 \_\_\_\_\_ #2 \_\_\_\_\_ #3 \_\_\_\_\_

**Tuberculin Test**

PPD Intradermal Date \_\_\_\_\_  
Date Read \_\_\_\_\_ Result \_\_\_\_\_ mm  
If Positive, Chest x-ray Date \_\_\_\_\_ Results \_\_\_\_\_

**REMARKS**

Please indicate any known allergies, medical conditions, medications and any restrictions for physical activities.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Full participation in school activities permitted.  
Please check box, if applies.

Physician's Signature

\_\_\_\_\_  
Physician's Name printed or use stamp