



## MINIMUM IMMUNIZATION REQUIREMENTS FOR SCHOOL ATTENDANCE IN NEW JERSEY

### **For Pre-school attendance (required BEFORE entering school):**

DTP/ DTaP (Diphtheria, Tetanus, Pertussis)- 4 doses

IPV/OPV (Polio)- 3 doses

MMR (Measles, Mumps, Rubella) - 1 dose

Varicella (Chickenpox)- 1 dose

Hib (Haemophilus influenzae B)- 1 dose

Pneumococcal- 1 dose

Influenza- 1 dose to be given between September 1 and December 31 of each year

### **For Kindergarten (required BEFORE entering school) through grades 5:**

DTP/DTaP- 4 doses with **one given on or after the 4th birthday**

IPV/OPV- 3 doses with **one given on or after the 4th birthday**

MMR- 2 doses

Varicella- 1 dose

Hep B (Hepatitis B)- 3 doses

### **For Sixth Grade attendance (required BEFORE the first day of school):**

All of the above plus:

Tdap (Tetanus, diphtheria and acellular pertussis)- 1 dose given no earlier than the 10th birthday

Meningococcal- 1 dose given on or after the 11th birthday (must provide school with documentation of receiving the vaccination after their birthday if student turns 11 after the start of the year)

Tuberculosis Screening (PPD/ Mantoux) will be required only of those students entering a United States school system for the first time who were born or living in a country listed by the New Jersey Department of Health and Senior Services as having a high incidence of TB (Tuberculosis).



HEALTH HISTORY and PHYSICAL EXAMINATION FORM

(To be completed by Physician)

Student's Name \_\_\_\_\_ Birth Date: \_\_\_\_\_  
Address \_\_\_\_\_ Telephone \_\_\_\_\_

Doctor's Name \_\_\_\_\_ Telephone \_\_\_\_\_  
Address \_\_\_\_\_

Father's Name \_\_\_\_\_  
Mother's Name \_\_\_\_\_

**Immunizations:** Please attach a copy of your child's updated immunization record from their primary care physician.

Health History Questionnaire:

Does your child have any ongoing or chronic illness? \_\_\_\_\_

Has your child had any recent injuries? \_\_\_\_\_

Has your child had surgery? \_\_\_\_\_

Does your child take any prescribed medications? \_\_\_\_\_

Does your child have any allergies or asthma? \_\_\_\_\_

Does your child have a life threatening allergy that may require the administration of an epinephrine auto-injector? \_\_\_\_\_

**\*\*\*If your child carries an epinephrine auto-injector (such as EPIPEN), please contact the school nurse as soon as possible to discuss the care of your child during the school year.\*\*\***

Are there any other health conditions that we should be aware of? \_\_\_\_\_

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