

CARLSTADT PUBLIC SCHOOLS  
IMMUNIZATION RECORD

NAME OF CHILD (Last, First, MI)					DATE OF BIRTH (Mo./Day/Yr.)	SEX <input type="checkbox"/> M <input type="checkbox"/> F	
NAME OF PARENT/GUARDIAN					TELEPHONE NUMBER(S)		
ADDRESS							
ADDRESS					IMMUNIZATION REGISTRY NUMBER		
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	LEAD SCREENING (Not Required)	
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination (if Td or DT <sup>(1)</sup> Indicate in corner box)						TEST DATE	RESULT
POLIO-INACTIVATED POLIO VACCINE (IPV) (if oral vaccine, indicate OPV in corner box)							
MEASLES, MUMPS, RUBELLA (MMR)						(5) Document below single antigen vaccine receipt, serology titers, or Varicella disease history	
HAEMOPHILUS B (HIB) (2)							
HEPATITIS B (3)					Hepatitis B	DATE:	TITER:
VARICELLA (4)					Varicella	DATE:	TITER:
PNEUMOCOCCAL CONJUGATE (2)					Measles	DATE:	TITER:
MENNIGOCOCCAL					Mumps	DATE:	DATE:
HEPATITIS A					Rubella	DATE:	DATE:
INFLUENZA (6)							
HPV (HUMAN PAPILLOMA VIRUS)							
OTHER, SPECIFY:							

Provisional Admission Attached - Date Granted: \_\_\_\_\_
  Medical Exemption Attached
  Religious Exemption Attached

- (1) REQUIRES MEDICAL EXEMPTION  
 (2) REQUIRED FOR CHILD CARE/PRESCHOOL ENROLLEES (2 Months - 5th Birthday Only)  
 (3) REQUIRED FOR K-GRADE 1 (whichever is first). GRADE 6 BEGINNING 9-1-01, AND GRADES 9-12, EFFECTIVE 9-1-04  
 (4) REQUIRED FOR DAY/CHILD CARE ENROLLED (19 Months and older) AND GRADE K-GRADE 1 (whichever is first) EFFECTIVE 9-1-04 IMM-8  
 (5) MMR single antigen receipt requires MO/DAY/YR, serology's require titers, and varicella disease history requires MO/YR  
 (6) REQUIRED FOR CHILD CARE/PRESCHOOL ENROLLEES (6 Months - 59 Months)

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CARLSTADT, NEW JERSEY  
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Below are the minimal immunization requirements for Pre-K and Kindergarten in New Jersey. The requirements for all school ages can be found on the [NJ website](http://www.nj.gov/education/students/safety/health/cdpr/immune/).

<http://www.nj.gov/education/students/safety/health/cdpr/immune/>

Please keep it with your child's health records as a reference .Whenever your child receives a vaccine please give the school a copy. Your physician may use the above immunization form or give the school a copy of your child's immunization record from their office.

All students entering the **pre-school** are required by law to provide document that they have received:

4 doses DTaP, 3 doses Polio, 1 dose MMR, 1 does HIB, 1 dose Varicella, 1 dose PVC7, and 1 does influenza. Influenza vaccine is to be given between September1 and December 31 of the school year.

In addition to the above, all students entering **Kindergarten** are required by law to provide documentation that they have received:

DPT and Polio DPT boosters given **after the fourth birthday**, a 2nd dose of a measles containing vaccine (MMR #2}, and 3 doses of Hepatitis B.

SIGNATURE OF PHYSICIAN \_\_\_\_\_ DATE: \_\_\_\_\_

PHYSICIAN'S NAME (*please print*) \_\_\_\_\_

PHYSICIAN'S ADDRESS \_\_\_\_\_