School year: _____

Dear Parents/Guardians of 5th grade students:

The State of New Jersey, Department of Health and Senior Services, has mandated that children born after January 1997 and entering 6th grade must receive a booster dose of Diphtheria, Pertussis and Tetanus (Tdap) and one dose of the Meningococcal vaccine. **Documentation of having received these vaccines MUST be provided by the time the child enters 6th grade.**

If your child receives these immunizations during his/her 5th grade school year, please send documentation to the Stony Brook School Nurse. If your child turns 11 during the summer and receives these immunizations, please send documentation to the Branchburg Central Middle School Nurse.

Thank you in advance for your attention to this matter

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Debra Warren RN
Stony Brook School

Mary Caputo RN MSN
Branchburg Central Middle School

MINIMAL IMMUNIZATION REQUIREMENTS FOR SCHOOL ATTENDANCE IN NEW JERSEY

Chapter 14: Immunization for Pupils in School

DISEASE(S)	MEETS IMMUNIZATION REQUIREMENTS	COMMENTS
Tdap	GRADE 6 *(or comparable age level for special education programs)*: 1 dose	For pupils entering Grade 6 on or after 9-1-08 and born on or after 1-1-97. A child does not need a Tdap dose until FIVE years after the last DTP/DtaP or Td dose.
MENINGOCOCCAL	(Entering GRADE 6 *(or comparable age level for Special Ed programs)*: 1 dose (1) (Entering a four-year college or University, previously unvaccinated and residing in a campus dormitory): 1 dose (2)	(1) For pupils entering Grade 6 on or after 9-1-08 and born on or after 1-1-97. (2) Previously unvaccinated students entering a four-year college or university after 9-1-04 and who reside in a campus dormitory, need 1 dose of meningococcal vaccine. Documentation of one prior dose is acceptable.

Student: _____ Date of Birth:_____

The above named student has received:

Tdap booster: _____ (Date m/d/y administered)

Meningococcal vaccine: _____ (Date m/d/y administered)

Physician/Provider Signature: _____

Physician/Provider Phone: _____ Physician/Provider Fax: _____

Physician/Provider (MD, DO, NP, PA) print name and address or stamp:

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