PEMBERTON TOWNSHIP SCHOOLS

Registration Requirements for Students

Please bring the following documents with you to Registration.

All Registrants Must Have:

- ☐ **Birth Certificate - *Must Have Raised Seal***
- ☐ **Immunization Record**
- ☐ **Proof of Residency (see below)**
- ☐ **Online Pre-Registration Confirmation Page**

If transferring from a school within State:

- ☐ **Transfer Card**

If transferring from a school out of State:

- ☐ **Current Report Card/Documentation from Sending School**

If this is the first time student is being registered for public school:

- ☐ **Universal Child Health Record - *Must by signed and stamped by student's physician***

Proof of Residency - Please provide the items listed below for your type of residency:

Homeowners

☐ One (1) of the following:
Property tax bill, Deed, Contracts of Sale, Mortgage, Township Bill (Water, Sewer, Trash, etc.)

Renters

☐ Lease

Military Living in Base Housing

☐ Housing Authority Permit or Lease
Note: School Option for Military Personnel will be enforced.

Residing with a Pemberton Township Resident

☐ One (1) of the following:

Residents who own the home must file an "Affidavit of Domicile" and provide proof of residency as a Homeowner (see above).

Residents who rent the home must provide a copy of their lease and an addendum by the landlord listing the additional person(s) living on the property.

☐ Three (3) of the following (***At least one guardian must be listed on each item.***):
Voter Registration, Licenses, Permits, Financial Account Information, Utility Bills (Electric, Gas, Cable, etc.), Delivery Receipts, other evidence of personal attachment to the residing address.

Guardianship

☐ All court documents pertaining to educational and/or residential custody.

PHONE: 609-893-8141 Ext. 1031 FAX: 609-726-5660 EMAIL: hvargas@pemb.org
Office: One Egbert Street, Pemberton, New Jersey 08068 • www.pemberton.k12.nj.us

Pemberton Learning Community: Pursuing Excellence One Child at a Time

PEMBERTON TOWNSHIP SCHOOLS

_____
Student Name

I, _____, have been informed by the Pemberton Township School District
(residential parent/guardian)
that I can only register students in Pemberton Township Schools if I am a resident of Pemberton Township.

I am aware that any person who makes a false statement or permits false statements to be made for the purpose of allowing a non-resident student to attend Pemberton Township Schools, commits a disorderly persons offense pursuant to N.J. 18A: 38-1 and may be prosecuted by law.

I authorize Pemberton Township Schools to investigate and confirm any and all statements by me and used in the enrollment of the above student. If any information is false, I am aware that enrollment in Pemberton Township Schools will be terminated.

A. By initialing I am stating:	***Initial One***
1. I am a resident of Pemberton Township	_____
2. I am temporarily residing in Pemberton Township with a resident	_____

B. By initialing I am stating that I am the:	***Initial One***
1. Parent/Guardian	_____
2. Parent and/or Guardian with residential custody (documentation provided)	_____
3. Sole Caretaker (Non-parent/Guardian) due to economic/family hardship	_____

C. By initialing I am stating that I understand:	***Initial***
1. Any changes in residency or custody will be reported immediately	_____

_____ _____
Signature of Parent/Guardian Date

_____ _____
District Official Date

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Pemberton Township School District Student Medical History

Since the health of a child can affect his/her ability to learn in school, please assist our school personnel in providing the following information:

Student Name: _____ Birthdate: _____ M___ F___

Current Health Information - Please answer all the following questions by circling Yes (Y) or No (N). If Yes (Y) is circled, please provide additional information in the space provided.

Y	N	Is your child now under the care of a physician for a medical or surgical problem?
Y	N	Does your child have any physical limitations or restrictions?

Has your child experienced any of the following? Please make sure to circle if it is an allergy *or* a sensitivity.

Circle One			**If yes, give specific details, dates and medication**
Y	N	Asthma	
Y	N	ADD *or* ADHD **(circle one)**	
Y	N	Medication **allergy** *or* **sensitivity (circle one)**	
Y	N	Bee sting **allergy** *or* **sensitivity (circle one)**	
Y	N	Food **allergy** *or* **sensitivity (circle one)**	
Y	N	Seasonal or environmental allergies - **specify ➔**	
Y	N	Diabetes	
Y	N	Frequent ear infections	
Y	N	Frequent bladder or kidney infections	
Y	N	Frequent nosebleeds	
Y	N	Seizure disorder	
Y	N	Headaches	
Y	N	High blood pressure	
Y	N	Heart conditions	
Y	N	Concussion/head injury requiring medical treatment	
Y	N	History of fainting with exercise	
Y	N	Operations (not stitches for lacerations)	
Y	N	Fractures (broken bones) or dislocations	
Y	N	Speech problems	
Y	N	Mental health concerns	
Y	N	Hearing concerns-hearing aid/implant/ear tubes	
Y	N	Vision concerns-wears glasses and/or contacts	
Y	N	Any chronic/serious illness not mentioned above	
Y	N	***Medication taken at home or in school**	

If medication is needed in school it MUST be brought to the health office in the original container with a physician's order. The child's parent/guardian is required to complete the Student Medication Permission Form. Medication orders must be renewed EVERY school year or participation in ANY activities (after school, field trips, etc.) will be denied.

Y	N	****Tylenol/acetaminophen or Motrin/Ibuprofen given by the nurse every 4-6 hours**

**Our school physician has written orders for the nurse to give the recommended OTC manufacturer's dosage of Tylenol/ acetaminophen or Motrin/ibuprofen every 4-6 hours as needed for pain/fever with your permission as per nurse's assessment. By signing this form you hereby release the Pemberton Township BOE and all school district personnel from liability.

I understand that relevant information regarding my child's health may be shared with the appropriate school personnel and other healthcare providers as necessary. In case of serious illness or injury, I request that the school contact me or the physician named. If neither is available, I give the school permission to make all necessary arrangements to obtain emergency care for my child including taking my child to the hospital. I will also call the school when my child is absent.

Signature: _____ Date: _____

Home Phone: _____ Cell Phone: _____

Doctor's Name: _____ Dr.'s Phone: _____

Dentist's Name: _____ Dentist's Phone: _____

PEMBERTON TOWNSHIP SCHOOLS

Dear Parent/Guardian,

The New Jersey Department of Education code states that each student's medical examination shall be conducted at the "medical home" (family physician) and recorded on a form supplied by the school. If the student does not have a "medical home" (family physician), the district shall provide this examination at the school's physician's office or other appropriate facility. Southern Jersey Family Medical Center performs physicals and other medical services. You can make an appointment by calling 1-800-486-0131. A student's "medical home" is defined as a health care provider and that provider's practice site is chosen by the student's parent or guardian for the provision of health care.

Each student shall be examined as REQUIRED below:

1. All students ages 3-5 upon initial entrance to school (initial entrance may be pre-school or kindergarten within the state of New Jersey.
2. All new students from out-of-state within 30 days of entry.
3. Student's participation in sports (Intramural and Interscholastic) grades 6-12.
   Please see your School Nurse for the specific form that must be used or download it from the district website.

*(A student transferring in from outside of the United States may need to be tested for tuberculosis. Your child's School Nurse will notify you if this applies to your child.)

It is <u>recommended</u> that subsequent physicals be done:

1. Pursuant to a comprehensive Child Study Team evaluation, if recommended.
2. During the student's pre-adolescence fourth through sixth grade.
3. During adolescent (7th through 12th grade).

If you do not have a medical provider (family physician) for your child, please contact your school nurse for information. Thank you for your cooperation.

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Parents/Guardians & Physicians:

- All sport physicals must be performed by the student's own doctor. If you do not have health insurance South Jersey Family Medical centers (609-894-1100) can provide services.
- The state required form is attached. This must be **filled out completely** by parent and physician. Incomplete forms will be returned and the student will be ineligible to participate in a sport until it is corrected.
- The Pre-Participation Physical Evaluation Form (4 pages) must be taken with you to the doctor. The parent completes the History Form/Supplemental History Form. Your physician must review the History Form/Supplemental History Form and then fill out the entire Physical Examination Form/Clearance Form.
- The Physical Examination Form/Clearance Form is good for 365 days or one calendar year. One calendar year is from date of physical until exact date the following year. (example – 3/2/20 to 3/2/21) If your child's physical should happen to expire in the middle of the sport season, they will be allowed to finish/complete that sport.
- A law has been passed by the state of NJ stating each sport physical must be reviewed and approved by the school physician **prior to any tryouts or practice.** It is imperative that all paperwork is completed and returned in a timely manner to ensure approval and eligibility for sports participation. The school physician will be available to sign the physical exam forms prior to the start of each season on his regular scheduled day - ***which is once a week***. If physicals are turned in after the school physician's scheduled day, there will be a turn around time of 7 to 14 days. **PLEASE PLAN AHEAD AND GET YOUR COMPLETED PHYSICAL TURNED IN *AT LEAST 2 OR MORE WEEKS PRIOR TO TRYOUTS.***
- Students with asthma, serious allergic reactions or diabetes are required by state law to have action plans completed **every school year**. If these forms are not returned, your child will not be able to participate in **any** after school activities (sports, clubs and trips).
- A Health History Update Questionnaire for Athletics must be completed every **90 days** or prior to a new seasonal sport (fall, winter, spring) per state law. The update informs us if your child has had any medical problems since his or her last physical. Explain all "yes" answers on parent form.

All forms are available in the nurse's office and can be downloaded from the PTHS website at: www.pemberton.k12.nj.us/pths (click on the "Athletics" Icon) or from the HFMS website at: www.pemberton.k12.nj.us/helenfort (click on the "Clubs & Activities" Tab and then, "Forms"). During the summer months, forms are also available in the main office.

- All physicals and medical forms must be turned into the **nurse's office**. This cuts down on lost paperwork. **We advise that you make copies for your records of any paperwork you send to the school.** We are unable to fax or make any copies for you.
- Parents and students must also sign that they reviewed the educational fact sheets on sports-related concussions and sudden cardiac death in young athletes, before any student participation in sports. This paperwork will be given out by the coaches and/or trainer.

Should you have any questions, feel free to call us at the school. Please remember that nurses do not work over the summer. If you should need assistance, call us during the school calendar year at 609-893-8141.

Newcomb School Nurse	ext. 1152	fax 609-757-4779
Helen Fort School Nurse	ext. 1685	fax 609-782-3580
High School Nurses	ext. 1084 & ext. 1085	fax 609-795-3984

APPENDIX H

UNIVERSAL CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)* *(First)*	Gender ☐ Male ☐ Female	Date of Birth / /
Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier	
Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -
Parent/Guardian Name	Home Telephone Number ( ) -	Work Telephone/Cell Phone Number ( ) -

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination: | Results of physical examination normal? ☐Yes ☐No

Abnormalities Noted:		
	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS ☐ Immunization Record Attached ☐ Date Next Immunization Due: _____

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	

This form should be maintained by the healthcare provider completing the physical exam (medical home). It should not be shared with schools. The medical eligibility form is the only form that should be submitted to a school. The physical exam must be completed by a healthcare provider who is a licensed physician, advanced practice nurse or physician assistant who has completed the Student-Athlete Cardiac Assessment Professional Development module hosted by the New Jersey Department of Education.

PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

HISTORY FORM

Note: Complete and sign this form (with your parents if younger than 18) before your appointment.

Name: _____ Date of birth: _____

Date of examination: _____ Sport(s): _____

Sex assigned at birth (F, M, or intersex): _____ How do you identify your gender? (F, M, non-binary, or another gender): _____

Have you had COVID-19? (check one): ☐ Y ☐ N

Have you been immunized for COVID-19? (check one): ☐ Y ☐ N If yes, have you had: ☐ One shot ☐ Two shots ☐ Three shots ☐ Booster date(s) _____

List past and current medical conditions. _____

Have you ever had surgery? If yes, list all past surgical procedures. _____

Medicines and supplements: List all current prescriptions, over-the-counter medicines, and supplements (herbal and nutritional).

Do you have any allergies? If yes, please list all your allergies (ie, medicines, pollens, food, stinging insects).

Patient Health Questionnaire Version 4 (PHQ-4)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle response.)

	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Little interest or pleasure in doing things	0	1	2	3
Feeling down, depressed, or hopeless	0	1	2	3

(A sum of ≥3 is considered positive on either subscale [questions 1 and 2, or questions 3 and 4] for screening purposes.)

GENERAL QUESTIONS (Explain "Yes" answers at the end of this form. Circle questions if you don't know the answer.)	Yes	No
1. Do you have any concerns that you would like to discuss with your provider?		
2. Has a provider ever denied or restricted your participation in sports for any reason?		
3. Do you have any ongoing medical issues or recent illness?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
4. Have you ever passed out or nearly passed out during or after exercise?		
5. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
6. Does your heart ever race, flutter in your chest, or skip beats (irregular beats) during exercise?		
7. Has a doctor ever told you that you have any heart problems?		
8. Has a doctor ever requested a test for your heart? For example, electrocardiography (ECG) or echocardiography.		

HEART HEALTH QUESTIONS ABOUT YOU (CONTINUED)	Yes	No
9. Do you get light-headed or feel shorter of breath than your friends during exercise?		
10. Have you ever had a seizure?		

HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	Unsure	Yes	No
11. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 35 years (including drowning or unexplained car crash)?			
12. Does anyone in your family have a genetic heart problem such as hypertrophic cardiomyopathy (HCM), Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy (ARVC), long QT syndrome (LQTS), short QT syndrome (SQTS), Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia (CPVT)?			
13. Has anyone in your family had a pacemaker or an implanted defibrillator before age 35?			

BONE AND JOINT QUESTIONS	Yes	No
14. Have you ever had a stress fracture or an injury to a bone, muscle, ligament, joint, or tendon that caused you to miss a practice or game?		
15. Do you have a bone, muscle, ligament, or joint injury that bothers you?		
MEDICAL QUESTIONS	**Yes**	**No**
16. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
17. Are you missing a kidney, an eye, a testicle, your spleen, or any other organ?		
18. Do you have groin or testicle pain or a painful bulge or hernia in the groin area?		
19. Do you have any recurring skin rashes or rashes that come and go, including herpes or methicillin-resistant *Staphylococcus aureus* (MRSA)?		
20. Have you had a concussion or head injury that caused confusion, a prolonged headache, or memory problems?		
21. Have you ever had numbness, had tingling, had weakness in your arms or legs, or been unable to move your arms or legs after being hit or falling?		
22. Have you ever become ill while exercising in the heat?		
23. Do you or does someone in your family have sickle cell trait or disease? **Unsure**		
24. Have you ever had or do you have any problems with your eyes or vision?		

MEDICAL QUESTIONS (CONTINUED)	Yes	No
25. Do you worry about your weight?		
26. Are you trying to or has anyone recommended that you gain or lose weight?		
27. Are you on a special diet or do you avoid certain types of foods or food groups?		
28. Have you ever had an eating disorder?		

MENSTRUAL QUESTIONS	N/A	Yes	No
29. Have you ever had a menstrual period?			
30. How old were you when you had your first menstrual period?			
31. When was your most recent menstrual period?			
32. How many periods have you had in the past 12 months?			

Explain "Yes" answers here.

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

This form should be maintained by the healthcare provider completing the physical exam (medical home). It should not be shared with schools. The Medical Eligibility Form is the only form that should be submitted to a school.

PREPARTICIPATION PHYSICAL EVALUATION

ATHLETES WITH DISABILITIES FORM: SUPPLEMENT TO THE ATHLETE HISTORY

Name:_____ Date of birth: _____

1. Type of disability:	
2. Date of disability:	
3. Classification (if available):	
4. Cause of disability (birth, disease, injury, or other):	
5. List the sports you are playing:	

	Yes	No
6. Do you regularly use a brace, an assistive device, or a prosthetic device for daily activities?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or other skin problems?		
9. Do you have a hearing loss? Do you use a hearing aid?		
10. Do you have a visual impairment?		
11. Do you use any special devices for bowel or bladder function?		
12. Do you have burning or discomfort when urinating?		
13. Have you had autonomic dysreflexia?		
14. Have you ever been diagnosed as having a heat-related (hyperthermia) or cold-related (hypothermia) illness?		
15. Do you have muscle spasticity?		
16. Do you have frequent seizures that cannot be controlled by medication?		

Explain "Yes" answers here.

_____

_____

_____

Please indicate whether you have ever had any of the following conditions:

	Yes	No
Atlantoaxial instability		
Radiographic (x-ray) evaluation for atlantoaxial instability		
Dislocated joints (more than one)		
Easy bleeding		
Enlarged spleen		
Hepatitis		
Osteopenia or osteoporosis		
Difficulty controlling bowel		
Difficulty controlling bladder		
Numbness or tingling in arms or hands		
Numbness or tingling in legs or feet		
Weakness in arms or hands		
Weakness in legs or feet		
Recent change in coordination		
Recent change in ability to walk		
Spina bifida		
Latex allergy		

Explain "Yes" answers here.

_____

_____

_____

I hereby state that, to the best of my knowledge, my answers to the questions on this form are complete and correct.

Signature of athlete: _____

Signature of parent or guardian: _____

Date: _____

This form should be maintained by the healthcare provider completing the physical exam (medical home). It should not be shared with schools. The medical eligibility form is the only form that should be submitted to a school. The physical exam must be completed by a healthcare provider who is a licensed physician, advanced practice nurse or physician assistant who has completed the Student - Athlete Cardiac Assessment Professional Development module Hosted by the New Jersey Department of Education.

PREPARTICIPATION PHYSICAL EVALUATION (Interim Guidance)

PHYSICAL EXAMINATION FORM

Name: _____ Date of birth: _____

PHYSICIAN REMINDERS

1. Consider additional questions on more-sensitive issues.
   - Do you feel stressed out or under a lot of pressure?
   - Do you ever feel sad, hopeless, depressed, or anxious?
   - Do you feel safe at your home or residence?
   - Have you ever tried cigarettes, e-cigarettes, chewing tobacco, snuff, or dip?
   - During the past 30 days, did you use chewing tobacco, snuff, or dip?
   - Do you drink alcohol or use any other drugs?
   - Have you ever taken anabolic steroids or used any other performance-enhancing supplement?
   - Have you ever taken any supplements to help you gain or lose weight or improve your performance?
   - Do you wear a seat belt, use a helmet, and use condoms?
2. Consider reviewing questions on cardiovascular symptoms (Q4–Q13 of History Form).

EXAMINATION		
Height:	Weight:	
BP: / (/)	Pulse:	Vision: R 20/ L 20/ Corrected: ☐ Y ☐ N
COVID-19 VACCINE		
Previously received COVID-19 vaccine: ☐ Y ☐ N		
Administered COVID-19 vaccine at this visit: ☐ Y ☐ N If yes: ☐ First dose ☐ Second dose ☐ Third dose ☐ Booster date(s) _____		
MEDICAL	**NORMAL**	**ABNORMAL FINDINGS**
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, hyperlaxity, myopia, mitral valve prolapse [MVP], and aortic insufficiency)		
Eyes, ears, nose, and throat • Pupils equal • Hearing		
Lymph nodes		
Heart[a] • Murmurs (auscultation standing, auscultation supine, and ± Valsalva maneuver)		
Lungs		
Abdomen		
Skin • Herpes simplex virus (HSV), lesions suggestive of methicillin-resistant *Staphylococcus aureus* (MRSA), or tinea corporis		
Neurological		
MUSCULOSKELETAL	**NORMAL**	**ABNORMAL FINDINGS**
Neck		
Back		
Shoulder and arm		
Elbow and forearm		
Wrist, hand, and fingers		
Hip and thigh		
Knee		
Leg and ankle		
Foot and toes		
Functional • Double-leg squat test, single-leg squat test, and box drop or step drop test		

[a] Consider electrocardiography (ECG), echocardiography, referral to a cardiologist for abnormal cardiac history or examination findings, or a combination of those.

Name of health care professional (print or type): _____ Date: _____

Address: _____ Phone: _____

Signature of health care professional: _____, MD, DO, NP, or PA

Preparticipation Physical Evaluation Medical Eligibility Form

The Medical Eligibility Form is the only form that should be submitted to school. It should be kept on file with the student's school health record.

Student Athlete's Name _____ Date of Birth _____

Date of Exam _____

- o Medically eligible for all sports without restriction
- o Medically eligible for all sports without restriction with recommendations for further evaluation or treatment of
- o Medically eligible for certain sports
- o Not medically eligible pending further evaluation
- o Not medically eligible for any sports

Recommendations: _____

I have reviewed the history form and examined the student named on this form and completed the preparticipation physical evaluation. The athlete does not have apparent clinical contraindications to practice and can participate in the sport(s) as outlined on this form. A copy of the physical examination findings- are on record in my office and can be made available to the school at the request of the parents. If conditions arise after the athlete has been cleared for participation, the physician may rescind the medical eligibility until the problem is resolved and the potential consequences are completely explained to the athlete (and parents or guardians).

Signature of physician, APN, PA _____

Address: _____

Name of healthcare professional (print) _____

I certify I have completed the Cardiac Assessment Professional Development Module developed by the New Jersey Department of Education.

Signature of healthcare provider _____

Shared Health Information

Allergies _____

Medications:

Other information: _____

Emergency Contacts: _____

**This form has been modified to meet the statutes set forth by New Jersey*

New Jersey Department of Health

MINIMUM IMMUNIZATION REQUIREMENTS FOR SCHOOL ATTENDANCE IN NEW JERSEY
N.J.A.C. 8:57-4: IMMUNIZATION OF PUPILS IN SCHOOL

Disease(s)	Meets Immunization Requirements	Comments
DTaP/DTP	**Age 1-6 years:** 4 doses, with one dose given on or after the 4th birthday, OR any 5 doses. **Age 7-9 years:** 3 doses of Td or any previously administered combination of DTP, DTaP, and DT to equal 3 doses	Any child entering pre-school, and/or pre-Kindergarten needs a minimum of 4 doses. A booster dose is needed on or after the fourth birthday, to be in compliance with Kindergarten attendance requirements. Pupils after the seventh birthday should receive adult type Td. Please note: there is no acceptable titer test for pertussis.
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 is not required to have a Tdap dose until FIVE years after the last DTP/DTaP or Td dose.
Polio	**Age 1-6 years:** 3 doses, with one dose given on or after the 4th birthday, OR any 4 doses. **Age 7 or Older:** Any 3 doses	Any child entering pre-school, and/or pre-Kindergarten needs a minimum of 3 doses. A booster dose is needed on or after the fourth birthday to be in compliance with Kindergarten attendance requirements. Either inactivated polio vaccine (IPV) or oral polio vaccine (OPV) separately or in combination is acceptable. Polio vaccine is not required of pupils 18 years or older.*
Measles	If born before 1-1-90, 1 dose of a live measles-containing vaccine on or after the first birthday. If born on or after 1-1-90, 2 doses of a live measles-containing vaccine on or after the first birthday.	Any child over 15 months of age entering child care, pre-school, or pre-Kindergarten needs a minimum of 1 dose of measles vaccine. Any child entering Kindergarten needs 2 doses. Intervals between first and second measles-containing vaccine doses cannot be less than 1 month. Laboratory evidence of immunity is acceptable.**
Rubella and Mumps	1 dose of live mumps-containing vaccine on or after the first birthday. 1 dose of live rubella-containing vaccine on or after the first birthday	Any child over 15 months of age entering child care, pre-school, or pre-Kindergarten needs 1 dose of rubella and mumps vaccine. Any child entering Kindergarten needs 1 dose each. Laboratory evidence of immunity is acceptable. **
Varicella	1 dose on or after the first birthday	All children 19 months of age and older enrolled into a child care/pre-school center after 9-1-04 or children born on or after 1-1-98 entering the school for the first time in Kindergarten or Grade 1 need 1 dose of varicella vaccine. Laboratory evidence of immunity, physician's statement or a parental statement of previous varicella disease is acceptable.
Haemophilus Influenzae B (Hib)	**Age 2-11 Months:** 2 doses **Age 12-59 Months:** 1 dose	Mandated only for children enrolled in child care, pre-school, or pre-Kindergarten: Minimum of 2 doses of Hib-containing vaccine is needed if between the ages of 2-11 months. Minimum of 1 dose of Hib-containing vaccine is needed after the first birthday. ***
Hepatitis B	**K-Grade 12**: 3 doses or **Age 11-15 years**: 2 doses	If a child is between 11-15 years of age and has not received 3 prior doses of Hepatitis B then the child is eligible to receive 2-dose Hepatitis B Adolescent formulation.
Pneumococcal	**Age 2-11 months:** 2 doses **Age 12-59 months:** 1 dose	Mandated only for children enrolled in child care, pre-school, or pre-Kindergarten: Minimum of 2 doses of pneumococcal conjugate vaccine is needed if between the ages of 2-11 months. Minimum of 1 dose of pneumococcal conjugate vaccine is needed after the first birthday. ***
Meningococcal	Entering Grade 6 (or comparable age level for Special Ed programs): 1 dose	For pupils entering Grade 6 on or after 9-1-08 and born on or after 1-1-97. *** This applies to students when they turn 11 years of age and attending Grade 6.
Influenza	**Ages 6-59 Months:** 1 dose annually	For children enrolled in child care, pre-school, or pre-Kindergarten on or after 9-1-08, 1 dose to be given between September 1 and December 31 of each year. Students entering school after December 31 up until March 31 must receive 1 dose since it is still flu season during this time period.

IMM

MINIMUM IMMUNIZATION REQUIREMENTS FOR SCHOOL ATTENDANCE IN NEW JERSEY
N.J.A.C. 8:57-4: IMMUNIZATION OF PUPILS IN SCHOOL

*** Footnote**: The requirement to receive a school entry booster dose of DTP or DTaP after the child's 4th birthday shall not apply to children while in child care centers, preschool or pre-kindergarten classes or programs.

The requirement to receive a school entry dose of OPV or IPV after the child's 4th birthday shall not apply to children while in child care centers, preschool or pre-kindergarten classes or programs.

**** Footnote**: Antibody Titer Law (Holly's Law)—This law specifies that a titer test demonstrating immunity be accepted in lieu of receiving the second dose of measles-containing vaccine. The tests used to document immunity must be approved by the U.S. Food and Drug Administration (FDA) for this purpose and performed by a laboratory that is CLIA certified.

***** Footnote**: No acceptable immunity tests currently exist for Haemophilus Influenzae type B, Pneumococcal, and Meningococcal.

Please Note The Following:

The specific vaccines and the number of doses required are intended to establish the minimum vaccine requirements for child-care center, preschool, or school entry and attendance in New Jersey. These intervals are not based on the allotted time to receive vaccinations. The intervals indicate the vaccine doses needed at earliest age at school entry. Additional vaccines, vaccine doses, and proper spacing between vaccine doses are recommended by the Department in accordance with the guidelines of the American Academy of Pediatrics (AAP) and Advisory Committee on Immunization Practices (ACIP), as periodically revised, for optimal protection and additional vaccines or vaccine doses may be administered, although they are not required for school attendance unless otherwise specified.

Serologic evidence of immunity (titer testing) is only accepted as proof of immunity when no vaccination documentation can be provided or prior history is questionable. It cannot be used in lieu of receiving the full recommended vaccinations.

Provisional Admission:
Provisional admission allows a child to enter/attend school after having received a minimum of one dose of each of the required vaccines. Pupils must be actively in the process of completing the series. Pupils <5 years of age, must receive the required vaccines within 17 months in accordance with the ACIP recommended minimum vaccination interval schedule. Pupils 5 years of age and older, must receive the required vaccines within 12 months in accordance with the ACIP recommended minimum vaccination interval schedule.

Grace Periods:

- 4-day grace period: All vaccine doses administered less than or equal to four days before either the specified minimum age or dose spacing interval shall be counted as valid and shall not require revaccination in order to enter or remain in a school, pre-school, or child care facility.
- 30-day grace period: Those children transferring into a New Jersey school, pre-school, or child care center from out of state/out of country may be allowed a 30-day grace period in order to obtain past immunization documentation before provisional status shall begin.