You can get there from here!

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

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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 or No

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 ever experienced any of the following?

Circle one			*If yes, indicate date, details, 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	Diabetes	
Y	N	Frequent ear infections	
Y	N	Frequent bladder or kidney infections	
Y	N	Frequent nose bleeds	
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	Need for hearing aide/implant/ear tubes/hearing concerns	
Y	N	Wears glasses and/or contact lenses/vision concerns	
Y	N	Any chronic/serious illness not mentioned above	
Y	**N**	***Medication 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 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 health care 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: _____

PTS
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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

ATTENTION PARENT/GUARDIAN: The preparticipation physical examination (page 3) must be completed by a health care provider who has completed the Student-Athlete Cardiac Assessment Professional Development Module.

PREPARTICIPATION PHYSICAL EVALUATION
HISTORY FORM

(Note: This form is to be filled out by the patient and parent prior to seeing the physician. The physician should keep a copy of this form in the chart.)

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

Medicines and Allergies: Please list all of the prescription and over-the-counter medicines and supplements (herbal and nutritional) that you are currently taking

_____

_____

_____

Do you have any allergies? ☐ Yes ☐ No If yes, please identify specific allergy below.

☐ Medicines ☐ Pollens ☐ Food ☐ Stinging insects

Explain "Yes" answers below. Circle questions you don't know the answers to.

GENERAL QUESTIONS	Yes	No
1. Has a doctor ever denied or restricted your participation in sports for any reason?		
2. Do you have any ongoing medical conditions? If so, please identify below: ☐ Asthma ☐ Anemia ☐ Diabetes ☐ Infections Other: _____		
3. Have you ever spent the night in the hospital?		
4. Have you ever had surgery?		
HEART HEALTH QUESTIONS ABOUT YOU	**Yes**	**No**
5. Have you ever passed out or nearly passed out DURING or AFTER exercise?		
6. Have you ever had discomfort, pain, tightness, or pressure in your chest during exercise?		
7. Does your heart ever race or skip beats (irregular beats) during exercise?		
8. Has a doctor ever told you that you have any heart problems? If so, check all that apply: ☐ High blood pressure ☐ A heart murmur ☐ High cholesterol ☐ A heart infection ☐ Kawasaki disease Other: _____		
9. Has a doctor ever ordered a test for your heart? (For example, ECG/EKG, echocardiogram)		
10. Do you get lightheaded or feel more short of breath than expected during exercise?		
11. Have you ever had an unexplained seizure?		
12. Do you get more tired or short of breath more quickly than your friends during exercise?		
HEART HEALTH QUESTIONS ABOUT YOUR FAMILY	**Yes**	**No**
13. Has any family member or relative died of heart problems or had an unexpected or unexplained sudden death before age 50 (including drowning, unexplained car accident, or sudden infant death syndrome)?		
14. Does anyone in your family have hypertrophic cardiomyopathy, Marfan syndrome, arrhythmogenic right ventricular cardiomyopathy, long QT syndrome, short QT syndrome, Brugada syndrome, or catecholaminergic polymorphic ventricular tachycardia?		
15. Does anyone in your family have a heart problem, pacemaker, or implanted defibrillator?		
16. Has anyone in your family had unexplained fainting, unexplained seizures, or near drowning?		
BONE AND JOINT QUESTIONS	**Yes**	**No**
17. Have you ever had an injury to a bone, muscle, ligament, or tendon that caused you to miss a practice or a game?		
18. Have you ever had any broken or fractured bones or dislocated joints?		
19. Have you ever had an injury that required x-rays, MRI, CT scan, injections, therapy, a brace, a cast, or crutches?		
20. Have you ever had a stress fracture?		
21. Have you ever been told that you have or have you had an x-ray for neck instability or atlantoaxial instability? (Down syndrome or dwarfism)		
22. Do you regularly use a brace, orthotics, or other assistive device?		
23. Do you have a bone, muscle, or joint injury that bothers you?		
24. Do any of your joints become painful, swollen, feel warm, or look red?		
25. Do you have any history of juvenile arthritis or connective tissue disease?		

MEDICAL QUESTIONS	Yes	No
26. Do you cough, wheeze, or have difficulty breathing during or after exercise?		
27. Have you ever used an inhaler or taken asthma medicine?		
28. Is there anyone in your family who has asthma?		
29. Were you born without or are you missing a kidney, an eye, a testicle (males), your spleen, or any other organ?		
30. Do you have groin pain or a painful bulge or hernia in the groin area?		
31. Have you had infectious mononucleosis (mono) within the last month?		
32. Do you have any rashes, pressure sores, or other skin problems?		
33. Have you had a herpes or MRSA skin infection?		
34. Have you ever had a head injury or concussion?		
35. Have you ever had a hit or blow to the head that caused confusion, prolonged headache, or memory problems?		
36. Do you have a history of seizure disorder?		
37. Do you have headaches with exercise?		
38. Have you ever had numbness, tingling, or weakness in your arms or legs after being hit or falling?		
39. Have you ever been unable to move your arms or legs after being hit or falling?		
40. Have you ever become ill while exercising in the heat?		
41. Do you get frequent muscle cramps when exercising?		
42. Do you or someone in your family have sickle cell trait or disease?		
43. Have you had any problems with your eyes or vision?		
44. Have you had any eye injuries?		
45. Do you wear glasses or contact lenses?		
46. Do you wear protective eyewear, such as goggles or a face shield?		
47. Do you worry about your weight?		
48. Are you trying to or has anyone recommended that you gain or lose weight?		
49. Are you on a special diet or do you avoid certain types of foods?		
50. Have you ever had an eating disorder?		
51. Do you have any concerns that you would like to discuss with a doctor?		
FEMALES ONLY		
52. Have you ever had a menstrual period?		
53. How old were you when you had your first menstrual period?		
54. How many periods have you had in the last 12 months?		

Explain "yes" answers here

_____

_____

_____

_____

_____

_____

_____

_____

_____

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

Signature of athlete _____ Signature of parent/guardian _____ Date _____

PREPARTICIPATION PHYSICAL EVALUATION
THE ATHLETE WITH SPECIAL NEEDS: SUPPLEMENTAL HISTORY FORM

Date of Exam _____

Name _____ Date of birth _____

Sex _____ Age _____ Grade _____ School _____ Sport(s) _____

1. Type of disability
2. Date of disability
3. Classification (if available)
4. Cause of disability (birth, disease, accident/trauma, other)
5. List the sports you are interested in playing

	Yes	No
6. Do you regularly use a brace, assistive device, or prosthetic?		
7. Do you use any special brace or assistive device for sports?		
8. Do you have any rashes, pressure sores, or any 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 with 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 if you have ever had any of the following.

	Yes	No
Atlantoaxial instability		
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 above questions are complete and correct.

Signature of athlete _____ Signature of parent/guardian _____ Date _____

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

NOTE: The preparticipation physical examination must be conducted by a health care provider who 1) is a licensed physician, advanced practice nurse, or physician assistant; and 2) completed the Student-Athlete Cardiac Assessment Professional Development Module.

■ PREPARTICIPATION PHYSICAL EVALUATION
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, 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 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 (questions 6–14).

MEDICAL	NORMAL	ABNORMAL FINDINGS
Height _____ Weight _____ ☐ Male ☐ Female		
BP ____/____ (____/____) Pulse _____ Vision R 20/_____ L 20/_____ Corrected ☐ Y ☐ N		
Appearance • Marfan stigmata (kyphoscoliosis, high-arched palate, pectus excavatum, arachnodactyly, arm span > height, hyperlaxity, myopia, MVP, aortic insufficiency)		
Eyes/ears/nose/throat • Pupils equal • Hearing		
Lymph nodes		
Heart* • Murmurs (auscultation standing, supine, +/- Valsalva) • Location of point of maximal impulse (PMI)		
Pulses • Simultaneous femoral and radial pulses		
Lungs		
Abdomen		
Genitourinary (males only)†		
Skin • HSV, lesions suggestive of MRSA, tinea corporis		
Neurologic‡		
MUSCULOSKELETAL		
Neck		
Back		
Shoulder/arm		
Elbow/forearm		
Wrist/hand/fingers		
Hip/thigh		
Knee		
Leg/ankle		
Foot/toes		
Functional • Duck-walk, single leg hop		

*Consider ECG, echocardiogram, and referral to cardiology for abnormal cardiac history or exam.
†Consider GU exam if in private setting. Having third party present is recommended.
‡Consider cognitive evaluation or baseline neuropsychiatric testing if a history of significant concussion.

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

_____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is 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, a physician may rescind the clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) (print/type) _____ Date of exam _____

Address _____ Phone _____

Signature of physician, APN, PA _____

ME540 8-2010410
New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

PREPARTICIPATION PHYSICAL EVALUATION
CLEARANCE FORM

Name _____ Sex ☐ M ☐ F Age _____ Date of birth _____

☐ Cleared for all sports without restriction

☐ Cleared for all sports without restriction with recommendations for further evaluation or treatment for _____

_____

☐ Not cleared

- ☐ Pending further evaluation
- ☐ For any sports
- ☐ For certain sports _____

Reason _____

Recommendations _____

EMERGENCY INFORMATION

Allergies _____

Other information _____

HCP OFFICE STAMP

SCHOOL PHYSICIAN:

Reviewed on _____
(Date)

Approved _____ Not Approved _____

Signature: _____

I have examined the above-named student and completed the preparticipation physical evaluation. The athlete does not present apparent clinical contraindications to practice and participate in the sport(s) as outlined above. A copy of the physical exam is 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 clearance until the problem is resolved and the potential consequences are completely explained to the athlete (and parents/guardians).

Name of physician, advanced practice nurse (APN), physician assistant (PA) _____ Date _____

Address _____ Phone _____

Signature of physician, APN, PA _____

Completed Cardiac Assessment Professional Development Module

Date _____ Signature _____

New Jersey Department of Education 2014; Pursuant to P.L.2013, c.71

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.

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

*** 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.