NEW PROVIDENCE SCHOOL DISTRICT
356 Elkwood Avenue
New Providence, New Jersey 07974

IMMUNIZATION RECORD

Student Name _____ Date of Birth _____

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	
						Test Date	Result
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination – *If Td or DT, indicate in corner box)*							
Tdap							
POLIO – INACTIVATED POLIO VACCINE (IPV)–If oral vaccine, indicate (OPV) in corner box							
MEASLES, MUMPS, RUBELLA (MMR)					Document below single antigen vaccine receipt, serology titers, or varicella disease history.		
HAEMOPHILUS B (HIB) **							
HEPATITIS B					Hepatitis B	Date:	Titer:
VARICELLA					Varicella	Date:	Titer:
PNEUMOCOCCAL CONJUGATE **					Measles	Date:	Titer:
MENINGOCOCCAL					Mumps	Date:	Titer:
HEPATITIS A ***					Rubella	Date:	Titer:
HPV (HUMAN PAPILLOMAVIRUS) ***							
OTHER							

_____ _____
Physician Signature Date

For school entry, the following immunizations are required:

- **4 doses of DTP/DTAP/DT minimum**
  4th dose must be given on or after the fourth birthday or 5 doses are required
- **3 doses of a polio vaccine (OPV or IPV) minimum**
  3rd dose must be given on or after the fourth birthday or 4 doses are required
- **2 doses of a measles-containing vaccine (MMR)**
  1st dose must be given on or after the first birthday
- **3 doses of hepatitis B vaccine**
  2 doses of Recombivax HB will be accepted for students age 11-15 only
- **1 dose of a varicella vaccine (chicken pox)**
  1st dose must be given on or after the first birthday for all students born after January 1, 1998 unless physician or parent submit a statement of past history of varicella disease

Effective September 2008, these additional immunizations will be required for Grade 6 entry: **1 dose of the meningococcal conjugate vaccine 1 dose of DTAP**

Preschool Students:

- **Complete series of pneumococcal conjugate vaccine (PCV)** before entering preschool
- **Influenza Vaccine** between September 1st and December 31st **annually**

FOR KINDERGARTEN ENTRY: Return this form **before the first day of school** after all required immunizations have been recorded.

STUDENT HEALTH EXAMINATION

Student's Name _____ Date of Birth _____

Address _____ Phone ( ) _____ School _____

CIRCLE: New Student Kindergarten Entry Other _____

To Be Completed By Physician: **DATE OF EXAMINATION** _____

Height _____ Weight _____ Blood Pressure _____

Most recent Mantoux: Date Given _____ Date Read _____ Results _____

Check each line	Normal	Abnormal	Needs Follow-up	Not Examined
Ears				
Eyes				
Lymph Glands				
Thyroid				
Nose				
Throat				
Teeth - Mouth				
Heart				
Lungs				
Abdomen				
Hernia				
Genito - Urinary				
Orthopedic				
Scoliosis				
Skin				
Nutrition				
Nervous System				
Speech				
General Appearance				

Immunization Administered: _____

Comments: _____

May Participate in school activities without limitation: _____ Yes _____No

If no, specify limits: _____

Does student have any health conditions currently requiring treatment? _____Yes ____No

If yes, specify: _____

_____ Physician (print or stamp)

_____ Physician Signature

AN OFFICIAL IMMUNIZATION RECORD, SIGNED BY A PHYSICIAN, IS REQUIRED FOR SCHOOL ENTRY. THIS FORM MAY BE USED IF NEEDED.