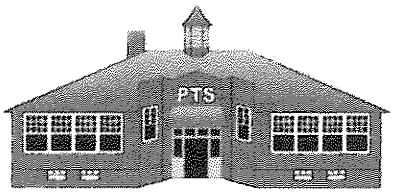


You can get there from here!

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).

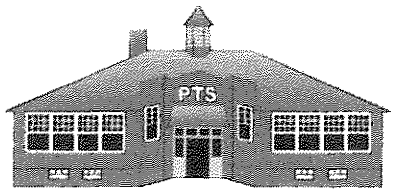
Residents who rent the home must provide a copy of their lease and an addendum by the landlord listing the additional person(s) living on the property.

☐ 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



You can get there from here!

PEMBERTON TOWNSHIP SCHOOLS

_____
Student Name

I, _____ (residential parent/guardian), have been informed by the Pemberton Township School District 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
Student Health History Questionnaire

Today's date: _____

Person completing this form: _____

Relationship to child: _____

GENERAL INFORMATION (please print)

Student's Full Name: _____

Date of Birth: _____ Age: _____ Grade: _____

Sex: ☐ Male or ☐ Female {check box}

Parent/Guardian Name:	Parent/Guardian Name:
Current Address:	Current Address:

How long at this address: _____ Language(s) spoken at home _____

Who lives in your household: _____

Home Phone Number: _____ Cell Phone Number: _____

Sibling Name: _____ DOB: _____

Sibling Name: _____ DOB: _____

Sibling Name: _____ DOB: _____

Sibling Name: _____ DOB: _____

Name of Previous School: _____

Address: _____

Is your child: ☐ Biological Child ☐ Adopted Child ☐ Foster Child ☐ Other _____

Child's Physician's Name: _____ Phone Number _____

Physician's Address: _____

II. HEALTH HISTORY - {please check box and provide explanation for only checked responses}

- ☐ Chicken Pox Explain: _____
- ☐ Strep Throat/Infections Explain: _____
- ☐ Lyme Disease Explain: _____
- ☐ Ear Infections Explain: _____
- ☐ Asthma Explain: _____
- ☐ Headaches Explain: _____
- ☐ Heart Problems Explain: _____
- ☐ Serious Allergies Explain: _____
- ☐ Food Allergies Explain: _____
- ☐ Drug Allergies Explain: _____
- ☐ Life Threatening Allergies Explain: _____
- ☐ Chronic Illnesses Explain: _____

(diabetes, cystic fibrosis, muscular dystrophy, kidney disease, cancer, metabolic disorders, etc.)

- ☐ Speech Problems Explain: _____
- ☐ Hearing Problems Explain: _____
- ☐ Vision Problems Explain: _____
- ☐ Seizures Explain: _____
- ☐ Orthopedic Problems Explain: _____
- ☐ Birth Defects Explain: _____
- ☐ Serious Illness or Accident Explain: _____
- ☐ Hospitalization or Surgery Explain: _____
- ☐ Bowel or Bladder Problems Explain: _____
- ☐ Adaptive aids Explain: _____

(glasses, hearing aid, wheelchair, braces, etc.)

Please check appropriate box below for conditions that describe the health of the child & mother during...

Mother's Pregnancy	Child's Delivery	Child's Condition at Birth
☐ No complications	☐ Normal	☐ Normal
☐ Blackouts	☐ Induced labor	☐ Lack of oxygen
☐ Falls	☐ C-section	☐ Breathing problem
☐ Physical injury	☐ Breech birth	☐ Birth injury/defect
☐ Excessive bleeding	☐ Unusually long labor (>12 hours)	☐ Jaundice
☐ Hypertension	☐ Premature # of weeks _____	☐ Newborn ICU # of days _____
☐ Diabetes	☐ Overdue # of weeks _____	☐ Other problem (specify)
☐ Emotional stress	☐ Other problem (specify)	_____
☐ Toxemia	_____	_____
☐ Alcohol and/or drug use	_____	_____
☐ Use of tobacco	_____	_____

III. CURRENT HEALTH/DEVELOPMENTAL STATUS

1. Describe the state of your child's current health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
2. Is your child currently taking any medication? ☐Yes ☐ No
   If yes, please list medications and uses: _____
   _____
3. If need be, would you have any objection to your child being placed in a peanut/ tree nut safe classroom? ☐Yes ☐ No
4. Does your child sleep in his/her own bed? ☐Yes ☐ No
5. Does your child share a room with anyone else? ☐Yes ☐ No
6. Does your child use toilet independently? ☐Yes ☐ No
   If no, describe assistance needed: _____
7. Are there any problems which might affect your child's learning? ☐Yes ☐ No
   If yes, describe: _____
8. Has your child received any type of therapy (i.e., counseling, speech therapy, physical therapy, occupational therapy, vision therapy, etc.) ☐Yes ☐ No
   If yes, describe: _____

9. Has your child ever had trouble walking, climbing, reaching, holding on to things?
   □Yes □ No If yes, describe: _____

10. At what age did your child …?
    - Sit up on his/her own _____
    - Crawl _____
    - Walk _____
    - Speak using single words _____
    - Speak using 2-3 word sentences _____

11. Can your child speak so that he/she can be understood by others? □Yes □ No

12. Do you have concerns about your child's willingness to try different foods?
    □Yes □ No If yes, describe: _____

13. Does your child sleep in his/her own bed? □Yes □ No

14. What time is your child's normal bedtime? _____

15. What time is your child's normal wake up time? _____

16. Do you have concerns about your child's sleeping patterns? □Yes □ No
    If yes, describe: _____

17. Is your child highly active? □Yes □ No

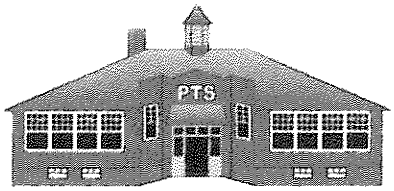
18. Is your child very quiet? □Yes □ No

19. Does your child talk with your friends/relatives who visit? □Yes □ No

20. Does your child have opportunities to play with other children? □Yes □ No

21. Any other information that you want to share? □Yes □ No
    If yes, describe: _____

****PLEASE RETURN THIS FORM TO THE SCHOOL NURSE****



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 recommended 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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Office: One Egbert Street, Pemberton, New Jersey 08068 • www.pemberton.k12.nj.us

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	

Instructions for Completing the Universal Child Health Record (CH-14)

Section 1 - Parent

Please have the parent/guardian complete the top section and sign the consent for the child care provider/school nurse to discuss any information on this form with the health care provider.

The WIC box needs to be checked only if this form is being sent to the WIC office. WIC is a supplemental nutrition program for Women, Infants and Children that provides nutritious foods, nutrition counseling, health care referrals and breast feeding support to income eligible families. For more information about WIC in your area call 1-800-328-3838.

Section 2 - Health Care Provider

1. Please enter the date of the physical exam that is being used to complete the form. Note significant abnormalities especially if the child needs treatment for that abnormality (e.g. creams for eczema; asthma medications for wheezing etc.)
   - **Weight** - Please note pounds vs. kilograms. If the form is being used for WIC, the weight must have been taken within the last 30 days.
   - **Height** - Please note inches vs. centimeters. If the form is being used for WIC, the height must have been taken within the last 30 days.
   - **Head Circumference** - Only enter if the child is less than 2 years.
   - **Blood Pressure** - Only enter if the child is 3 years or older.

2. **Immunization** - A copy of an immunization record may be copied and attached. If you need a blank form on which to enter the immunization dates, you can request a supply of Personal Immunization Record (IMM-9) cards from the New Jersey Department of Health, Vaccine Preventable Diseases Program at 609-826-4860.
   - The Immunization record must be attached for the form to be valid.
   - "Date next immunization is due" is optional but helps child care providers to assure that children in their care are up-to-date with immunizations.

3. **Medical Conditions** - Please list any ongoing medical conditions that might impact the child's health and well being in the child care or school setting.

   a. Note any significant medical conditions or major surgical history. **If the child has a complex medical condition, a special care plan should be completed and attached for any of the medical issue blocks that follow.** A generic care plan (CH-15) can be downloaded at www.nj.gov/health/forms/ch-15.dot or pdf. Hard copies of the CH-15 can be requested from the Division of Family Health Services at 609-292-5666.

   b. **Medications** - List any ongoing medications. Include any medications given at home if they might impact the child's health while in child care (seizure, cardiac or asthma medications, etc.). Short-term medications such as antibiotics do not need to be listed on this form. Long-term antibiotics such as antibiotics for urinary tract infections or sickle cell prophylaxis should be included.

      PRN Medications are medications given only as needed and should have guidelines as to specific factors that should trigger medication administration. *Please be specific about what over-the-counter (OTC) medications you recommend, and include information for the parent and child care provider as to dosage, route, frequency, and possible side effects. Many child care providers may require separate permissions slips for prescription and OTC medications.*

   c. **Limitations to physical activity** - Please be as specific as possible and include dates of limitation as appropriate. Any limitation to field trips should be noted. Note any special considerations such as avoiding sun exposure or exposure to allergens. Potential severe reaction to insect stings should be noted. Special considerations such as back-only sleeping for infants should be noted.

   d. **Special Equipment** – Enter if the child wears glasses, orthodontic devices, orthotics, or other special equipment. Children with complex equipment needs should have a care plan.

   e. **Allergies/Sensitivities** - Children with life-threatening allergies should have a special care plan. Severe allergic reactions to animals or foods (wheezing etc.) should be noted. Pediatric asthma action plans can be obtained from The Pediatric Asthma Coalition of New Jersey at www.pacnj.org or by phone at 908-687-9340.

   f. **Special Diets** - Any special diet and/or supplements that are medically indicated should be included. Exclusive breastfeeding should be noted.

   g. **Behavioral/Mental Health issues** – Please note any significant behavioral problems or mental health diagnoses such as autism, breath holding, or ADHD.

   h. **Emergency Plans** - May require a special care plan if interventions are complex. Be specific about signs and symptoms to watch for. Use simple language and avoid the use of complex medical terms.

4. **Screening** - This section is required for school, WIC, Head Start, child care settings, and some other programs. This section can provide valuable data for public heath personnel to track children's health. Please enter the date that the test was performed. Note if the test was abnormal or place an "N" if it was normal.
   - For lead screening state if the blood sample was capillary or venous and the value of the test performed.
   - For PPD enter millimeters of induration, and the date listed should be the date read. If a chest x-ray was done, record results.
   - Scoliosis screenings are done biennially in the public schools beginning at age 10.

   This form may be used for clearance for sports or physical education. As such, please check the box above the signature line and make any appropriate notations in the Limitation to Physical Activities block.

5. Please sign and date the form with the date the form was completed (note the date of the exam, if different)
   - Print the health care provider's name.
   - Stamp with health care site's name, address and phone number.

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.