

**ST. CATHERINE OF SIENA SCHOOL** *Pre-entrance physicals/completed immunizations*

**NJ STATE REQUIREMENTS**

<b>DPT</b>	Minimum of 4 doses; one dose must have been administered <b>on or after the 4th birthday</b> , or any 5 or more doses. <b>(NEW)</b> All students born after Jan. 1, 1997 and enrolled in 6th grade or transferring into a New Jersey school from another state or country must have a booster dose of diphtheria, tetanus and pertussis vaccine.
<b>Oral Polio</b>	Every students less than 7 years of age must have a minimum of 3 doses, provided one dose is given <b>on or after the 4th birthday</b> , or any 4 doses, at least 28 days apart.
<b>Measles</b>	Two doses given; first dose must be given <b>on or after the 1st birthday</b> . Vaccines are to be separated by no less than one month. (For 2nd dose, laboratory evidence of immunity is accepted.)
<b>Rubella</b>	One dose <b>on or after the 1st birthday</b> .
<b>Mumps</b>	One dose <b>on or after the 1st birthday</b> .
<b>HIB</b>	All children entering school must provide proof of HIB vaccinations appropriate for the child's age.
<b>Pneumococcal</b>	<b>(NEW)</b> All students in Pre School must have pneumococcal vaccine series, starting in September 2008.
<b>Hepatitis B</b>	3 doses of Hepatitis vaccine prior to school entrance for first time into Kindergarten or 1st grade.
<b>Varicella</b>	One dose <b>on or after the 1st birthday</b> or Physician/Parental history of disease or laboratory evidence of immunity.
<b>Meningococcal</b>	<b>(NEW)</b> All children born on or after Jan. 1, 1997 and enrolled in 6th grade or transferring into a New Jersey School from another state or country must have one dose of meningococcal vaccine.
<b>Flu Vaccine</b>	<b>(NEW)</b> Children in Pre School on or after Sept. 1, 2008 shall annually receive at least one dose of influenza vaccine between Sept. 1st and Dec. 31st of each year. (Children receiving first time vaccination receive 2 doses spaced 4 weeks apart.)
<b>TB (Mantoux)</b>	Provide the results of your child's most recent Tuberculin Test – if in Category (from country) indicated under NJ Tuberculosis guidelines.

**IMMUNIZATIONS**

**NAME OF CHILD** \_\_\_\_\_ **DOB** \_\_\_\_\_ **Sex:** Male \_\_\_\_ Female \_\_\_\_  
 Last First M.I. Mo/Day/Yr

<b>Parent or Guardian</b>	Name _____	Telephone # _____
	Address _____	<b>Name of Dr.</b> _____
	Address _____	<b>Dr.'s Tel. #</b> _____

Vaccine Type	DISEASE mo/day/yr	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	mo/day/yr
<b>DIPHTHERIA, TETANUS, PERTUSIS (DTP)</b> (If Td, DtaP, DT*, or TdaP indicate in box)							
<b>POLIO-ORAL POLIO VACCINE (OPV)</b> (If Salk Vaccine, indicate IPV in box)							
<b>MEASLES, MUMPS, RUBELLA (MMR)</b>							
<b>MEASLES</b>					Measles Serology:	Date:	Titer:
<b>RUBELLA</b>					Rubella Serology:	Date:	Titer:
<b>MUMPS</b>					Mumps Serology:	Date:	Titer:
<b>HAEMOPHILUS B (HIB)</b>							
<b>HEPATITIS B</b>							
<b>VARICELLA</b>							
<b>PNEUMOCOCCAL (PCV)</b>							
<b>MENINGOCOCCAL VACCINE</b>							
<b>INFLUENZA VACCINE</b>							

<input type="checkbox"/> Provisional Admission Attached - Date Granted:	<input type="checkbox"/> Medical Exemption Attached
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**MD:** \_\_\_\_\_

**MD Phone:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**Date:** \_\_\_\_\_

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