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

NJ STATE REQUIREMENTS

DPT	Minimum of 4 doses; one dose must have been administered **on or after the 4th birthday**, or any 5 or more doses. **(NEW)** 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.
Oral Polio	Every students less than 7 years of age must have a minimum of 3 doses, provided one dose is given **on or after the 4th birthday**, or any 4 doses, at least 28 days apart.
Measles	Two doses given; first dose must be given **on or after the 1st birthday**. Vaccines are to be separated by no less than one month. (For 2nd dose, laboratory evidence of immunity is accepted.)
Rubella	One dose **on or after the 1st birthday**.
Mumps	One dose **on or after the 1st birthday**.
HIB	All children entering school must provide proof of HIB vaccinations appropriate for the child's age.
Pneumoncoccal	**(NEW)** All students in Pre School must have pneumococcal vaccine series, starting in September 2008.
Hepatitis B	3 doses of Hepatitis vaccine prior to school entrance for first time into Kindergarten or 1st grade.
Varicella	One dose **on or after the 1st birthday** or Physician/Parental history of disease or laboratory evidence of immunity.
Meningococcal	**(NEW)** 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.
Flu Vaccine	**(NEW)** 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.)
TB (Mantaux)	Provide the results of your child's most recent Tuberculin Test – if in Category (from country) indicated under NJ Tuberculosis guidelines.

ST. CATHERINE OF SIENA SCHOOL • 39 E. Bradford Avenue, Cedar Grove, NJ 07009 • Tel: 973-239-6968

IMMUNIZATIONS

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

Parent	Name _____	Telephone #_____
or	Address _____	**Name of Dr.** _____
Guardian	Address _____	**Dr.'s Tel. #**_____

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

❑ Provisional Admission Attached - Date Granted:	❑ Medical Exemption Attached

MD: _____ **MD Phone:** _____

Address: _____ **Date:** _____

_____

5/2016