

GARFIELD PUBLIC SCHOOL DISTRICT

School Certification of Immunization

Student's Name _____

Date of Birth _____

School _____

In order to have a **complete** immunization record, all pupils entering Kindergarten in September will be required by the New Jersey State Department of Health, to provide documentation of the **complete date** and **type of vaccine** for the following immunizations:
 *required for admittance into school

VACCINE	TYPE of VACCINE	DATES GIVEN (month/day/year)
* Diphtheria, Tetanus, Pertussis (e.g., DTaP, DTaP-Hib,DTaP-HepB-IPV, DT, DTaP-Hib-IPV, Td) given IM.		
* Polio (e.g., IPV, DTaP-HepB-IPV, DTap-Hib-IPV, DTaP-IPV) Given SC or IM for IPV. Give all other IM.		
* Measles, Mumps, Rubella (e.g., MMR, MMRV)		
* Varicella (e.g., Var, MMRV) OR Disease history Disease date – month/year		
* Haemophilus influenza type b (e.g., Hib, Hib-HepB, DTaP-Hib-IPV, DTap-Hib)		
* Hepatitis B (e.g., HepB, Hib-HepB, DTaP-HepB-IPV)		
* Pneumococcal (e.g., PCV, conjugate;PPV, polysaccharide)		
* Meningococcal (e.g., MCV4;MPSV4, Menactra) TDAP		
Hepatitis A (e.g., HepA)		
Rotavirus (Rota)		
Human Papillomavirus (e.g., HPV)		
Influenza		
* Mantoux (include results)		

Physician's Signature _____

Physician's Name and Address _____

Date