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)
***Diphteria, 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		
Other		

_______________________________ Physician's Signature

_______________________________ Physician's Name and Address

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_______________________ Date

Rev.-4-2008