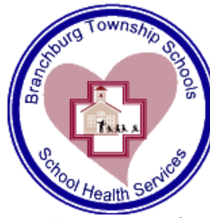

Janet Hoffman, RN, BSN, MEd
Certified School Nurse
Stony Brook School
136 Cedar Grove Road
Branchburg, NJ 08876
908-722-2400 #3 (phone)
908-722-4201 (fax)
jhoffman@branchburg.k12.nj.us

School year: ____________

Dear Parents/Guardians of 5th grade students:

The State of New Jersey, Department of Health and Senior Services, has mandated that children born after January 1997 and entering 6th grade must receive a booster dose of Diphtheria, Pertussis and Tetanus (Tdap) and one dose of the Meningococcal vaccine. **Documentation of having received these vaccines must be provided upon entry into 6th grade.** If your child receives these immunizations during his/her 5th grade school year, please send documentation to Mrs. Hoffman, the school nurse at Stony Brook School.

If you have any questions regarding this requirement, please contact the health office at your child's school.
Stony Brook School - 908-722-2400 #3

Thank you in advance for your attention to this matter

MAR 08

MINIMAL IMMUNIZATION REQUIREMENTS FOR SCHOOL ATTENDANCE IN NEW JERSEY
Chapter 14: Immunization for Pupils in School

DISEASE(S)	MEETS IMMUNIZATION REQUIREMENTS	COMMENTS
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 does not need a Tdap dose until FIVE years after the last DTP/DtaP or Td dose.
MENINGOCOCCAL	(Entering GRADE 6 *(or comparable age level for Special Ed programs)*: 1 dose (1) (Entering a four-year college or University, previously unvaccinated and residing in a campus dormitory): 1 dose (2)	(1) For pupils entering Grade 6 on or after 9-1-08 and born on or after 1-1-97. (2) Previously unvaccinated students entering a four-year college or university after 9-1-04 and who reside in a campus dormitory, need 1 dose of meningococcal vaccine. Documentation of one prior dose is acceptable.

Student: ____ Date of Birth: ___________________

The above named student has received:

Tdap booster: ______________________ (Date m/d/y administered)

Meningococcal vaccine: ______________________ (Date m/d/y administered)

Physician/Provider Signature: _________________________________

Physician/Provider Phone: ______________________ Physician/Provider Fax: ______________________

Physician/Provider (MD, DO, NP, PA) print name and address or stamp:

____
____
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