J. Brooks Hoffman '36 Health Center | Blair Academy
healthcenter@blair.edu | (phone) 908-362-2010 | (fax) 908-362-7885

IMMUNIZATION HISTORY FORM

To be completed by Healthcare Provider.

Student's Name: _____ Date of Birth: _____

ALL NEW STUDENTS: New Jersey Immunization Requirements are listed here; please have your Healthcare Provider complete the grid. Provider's office form is also acceptable with Office Stamp.

RETURNING STUDENTS: Please have your Healthcare Provider list ONLY newly received vaccines in the grid.

THE FOLLOWING VACCINES ARE REQUIRED FOR SCHOOL ATTENDANCE BY THE STATE OF NEW JERSEY:

4 doses	Tetanus, diphtheria & acellular pertussis	• 1 dose on or after 4th birthday • usually given as DTaP or DTP or DT or Td
1 dose	Tdap	• 1 dose after 10th birthday
1 dose	Polio	• 4 doses (4th dose not required if the third dose was given age 4 or over and at least 6 months after the previous dose). • Lab titer is NOT acceptable. IPV and tOPV are acceptable on a schedule that mirrors CDC recommendations. • If a child only received tOPV and doses were given before age 4, one dose of IPV at 4 yrs or older must be given- at least 6 months after last tOPV dose
2 doses	MMR	• 1st dose after 1st birthday or lab titer with evidence of immunity
3 doses	Hepatitis B	• **The minimum interval between the first and second dose:** Weeks after first dose - 4 weeks (28 days) • **There are three minimum intervals that must be met for the third dose:** Weeks after first dose - 16 weeks (112 days) Weeks after second dose - 8 weeks (56 days) Weeks after birth - 24 weeks (168 days) • If the first three doses do not meet the required minimum intervals above, a lab titer or 4th dose is required.
2 doses	Meningococcal (ACYW	• 1st dose given 11-15 years old; a second dose recommended at age 16 • If the first dose is given at age 16 or older, only one dose is required.
2 doses	Varicella	• One dose is required, or a statement of disease from Health Care Provider or Parent.
	Tuberculosis Screening Required by Blair Academy ***Please schedule with your Health Care Provider at the time of your physical.***	• ALL domestic students, must have a Tuberculosis Screening with either Tuberculin Skin Test (TST) or Interferon Gamma Release Assay (IGRA) Blood Test upon entry to Blair Academy (valid for their tenure at Blair). Please schedule with your Healthcare provider at the time of your physical appointment. • **ANNUALLY**, ALL international students from **High Burden TB** countries must have either a Tuberculin Skin Test (TST) or Interferon Gamma Release Assay (IGRA) Blood Test within 12 weeks prior to the start of the school year.

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Student's Name: _____ Date of Birth: _____

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RETURNING STUDENTS: Please have your Healthcare Provider list **ONLY the newly** received vaccines in the grid.

	1	2	3	4	5
DTaP, DPT, DT, TD					
Tdap (1 dose)					
Polio (OPV/IPV)					
MMR (2 doses)					
Hepatitis B (3 doses)					
Varicella Vaccine (1 dose or Lab Titer)					
Meningococcal ACYW					
Other Optional Vaccines (Please list here if applicable)					

TUBERCULOSIS (TB) ASSESSMENT AND TESTING

- **ALL STUDENTS (Returning, New, Domestic and International) must have their Healthcare Provider complete this section.**
- **ALL domestic students are required to have one Tuberculin Skin Test (TST) or Interferon Gamma Release Assay IGRA BLOOD TEST for TB within 12 weeks of start of school. This will be valid for their four year tenure at Blair.**
- **Annually**, ALL international students from High Burden TB countries http://www.stoptb.org/countries/tbdata.asp must have either a Tuberculin Skin Test (TST) or Interferon Gamma Release Assay (IGRA) Blood Test within 12 weeks prior to the start of the school year, The student is **REQUIRED** to have an **Tuberculin Skin Test (TST) or IGRA BLOOD TEST** no more than 12 weeks prior to attending school. If the TB test is positive, provide a chest x-ray report and details of any medication treatment below. Please submit copies of any lab work and chest x-ray results if applicable to healthcenter@blair.edu.

Furthermore, indicate if the student was previously diagnosed with ACTIVE or LATENT tuberculosis infection (Date) _____
Circle test performed
Tuberculin Skin Test: Date Placed _____ Date Read _____ Result _____ Induration (mm) _____
Blood Test (QFT Gold Plus, T-Spot, other) _____ Date _____ Result _____
Chest X-ray Date: _____ Result: _____
Treatment Details: _____

Date form completed: _____

Please note Health Care provider must be someone other than a parent.

Healthcare Provider Signature: _____

Healthcare Provider Name (Please Print): _____

Office Stamp:

Revised: 2/17/2021