

**MOUNT ARLINGTON PUBLIC SCHOOL DISTRICT**

**EDITH M. DECKER SCHOOL**

**446 HOWARD BOULEVARD**

**MOUNT ARLINGTON, NEW JERSEY 07856**

**TELEPHONE: 973-398-6400**

**FAX: 973-909-7100**

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**Student name** \_\_\_\_\_ **Date of birth** \_\_\_\_\_

**PRESCHOOL IMMUNIZATION REQUIREMENTS**

1. **DTP** (diphtheria, tetanus, & pertussis) - 4 doses.
2. **Polio** - 3 doses.
3. **Hib** (Haemophilus influenzae type b) - 1-4 doses, with at least 1 dose given on or after 1st birthday.
4. **PCV** (pneumococcal conjugate) - 1-4 doses, with at least 1 dose given on or after 1st birthday.
5. **MMR** (measles, mumps, rubella) - 1 dose, on or after 1st birthday.
6. **Varicella** (chicken pox) - 1 dose, on or after the 1st birthday.
7. **Influenza** - 1 dose, due annually by 12/31.

Dates must be completed **by your health care provider** in the spaces provided below before any child will be permitted to enter school. Alternatively attach a stamped immunization record from your healthcare provider.

**PROOF OF IMMUNIZATION**

DTP \_\_\_\_\_ Polio \_\_\_\_\_

Hib \_\_\_\_\_ PCV \_\_\_\_\_

MMR \_\_\_\_\_ Varicella \_\_\_\_\_ Influenza \_\_\_\_\_

Other \_\_\_\_\_

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**Printed Name/Address/Phone/Fax**

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**Health Care Provider Signature**

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**Date**