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**

Student name_____ **Date of birth**_____

IMMUNIZATION REQUIREMENTS (K-8)

1. **DTP** (diphtheria, tetanus, & pertussis)- 4 or 5 doses, with one dose on or after the 4th birthday
2. **Polio**- 3 or 4 doses, with one dose on or after the 4th birthday.
3. **MMR** (measles, mumps, rubella)- 2 doses.
4. **Varicella** (chicken pox)- 1 dose
5. **Hepatitis B**- 3 doses or (an approved 2-dose series).
6. **Meningococcal**- 1 dose for 7th grade and higher (given at age 10 and older).
7. **Tdap** (tetanus, diphtheria, acellular pertussis)- 1 dose for 7th grade and higher (given at age 10 and older).

Dates must be completed **by your health care provider** in the spaces provided below before any child will be permitted to enter school.

/Or/

Alternatively, attach a stamped immunization record from your healthcare provider.

PROOF OF IMMUNIZATION

DTP _____ _____ _____ _____ _____ Tdap_____

Polio _____ _____ _____ _____ MMR _____ _____

Varicella _____ _____ Hepatitis B _____ _____ _____ _____

Meningococcal _____Other_____

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Printed Name/Address/Phone/Fax

_____ _____

Health Care Provider Signature Date