

**New Jersey Department of Health
STANDARD SCHOOL / CHILD CARE CENTER IMMUNIZATION RECORD**

NAME OF CHILD (Last, First, MI)					DATE OF BIRTH (Mo/Day/Yr)	SEX <input type="checkbox"/> M <input type="checkbox"/> F
NAME OF PARENT/GUARDIAN					TELEPHONE NUMBER(S)	
ADDRESS						
ADDRESS					IMMUNIZATION REGISTRY NUMBER	
VACCINE TYPE	1ST DOSE MO/DAY/YR	2ND DOSE MO/DAY/YR	3RD DOSE MO/DAY/YR	4TH DOSE MO/DAY/YR	5TH DOSE MO/DAY/YR	EXEMPTIONS
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination (If Td or DT ⁽¹⁾ , indicate in corner box)						<input type="checkbox"/> Medical Exemption Attached <input type="checkbox"/> Religious Exemption Attached
POLIO-INACTIVATED POLIO VACCINE (IPV) (If oral vaccine, indicate OPV in corner box)						
MEASLES, MUMPS, RUBELLA (MMR)						(5) Document below single antigen vaccine receipt, serology titers, or varicella disease history
HAEMOPHILUS B (HIB)						
HEPATITIS B (HepB)					Hepatitis B	DATE: _____ TITER: _____
VARICELLA					Varicella	DATE: _____ TITER: _____
PNEUMOCOCCAL CONJUGATE (PCV13)					Measles	DATE: _____ TITER: _____
INFLUENZA					Mumps	DATE: _____ TITER: _____
OTHER, SPECIFY:					Rubella	DATE: _____ TITER: _____
OTHER, SPECIFY:					Comments:	
OTHER, SPECIFY:						
<input type="checkbox"/> Provisional Admission Date Granted: ____ / ____ / _____						

(1) REQUIRES MEDICAL EXEMPTION.

A complete list of New Jersey's immunization requirements is accessible at: http://nj.gov/health/cd/imm_requirements

IMM-8
NOV 18

J1081

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