



Livingston PUBLIC SCHOOLS

11 Foxcroft Drive
Livingston, NJ 07039

Phone: 973-535-8000
FAX: 973-535-1254

Immunization Compliance Request *(to be completed by a licensed health provider)*

Dear Parent/Guardian:

The Livingston Board of Education, in accordance with the State of New Jersey, must enforce the immunization requirements as mandated in the State Sanitary Code. The State Department of Health regulation requires the local Board of Education to exclude any student whose immunizations are not complete.

According to our records, the following information is missing from your child's health records. Documentation from your physician is required. To avoid exclusion, please give this matter your attention within the next ten (10) days. A form for your physician to complete follows on the next page.

Thank you.

School Nurse

Date

Immunization History

Student Name: _____ Date of Birth: _____

School: _____ Grade/Teacher: _____

DTaP:	1. _____ <i>mm/dd/yy</i>	2. _____ <i>mm/dd/yy</i>	3. _____ <i>mm/dd/yy</i>	4. _____ <i>mm/dd/yy</i>	5. _____ <i>mm/dd/yy</i>	
						<i>Booster</i>
Tdap:						_____
	<i>(for students born after January 1997 and students entering Grade 6)</i>					<i>Booster</i>
Polio	IPV:	1. _____ <i>mm/dd/yy</i>	2. _____ <i>mm/dd/yy</i>	3. _____ <i>mm/dd/yy</i>	4. _____ <i>mm/dd/yy</i>	5. _____ <i>mm/dd/yy</i>
	OPV:	1. _____ <i>mm/dd/yy</i>	2. _____ <i>mm/dd/yy</i>	3. _____ <i>mm/dd/yy</i>	4. _____ <i>mm/dd/yy</i>	5. _____ <i>mm/dd/yy</i>
MMR:	1. _____ <i>mm/dd/yy</i>	2. _____ <i>mm/dd/yy</i>	3. _____ <i>mm/dd/yy</i>			
Measles:	1. _____ <i>mm/dd/yy</i>	2. _____ <i>mm/dd/yy</i>				
Mumps:	1. _____ <i>mm/dd/yy</i>	2. _____ <i>mm/dd/yy</i>	Varicella Zoster:	1. _____ <i>mm/dd/yy</i>	2. _____ <i>mm/dd/yy</i>	
Rubella:	1. _____ <i>mm/dd/yy</i>	2. _____ <i>mm/dd/yy</i>				
HIB Vaccine:	1. _____ <i>mm/dd/yy</i>	2. _____ <i>mm/dd/yy</i>	3. _____ <i>mm/dd/yy</i>	4. _____ <i>mm/dd/yy</i>	5. _____ <i>mm/dd/yy</i>	
Hepatitis A Vaccine:	1. _____ <i>mm/dd/yy</i>		2. _____ <i>mm/dd/yy</i>			
Hepatitis B Vaccine:	1. _____ <i>mm/dd/yy</i>		2. _____ <i>mm/dd/yy</i>		3. _____ <i>mm/dd/yy</i>	
PPD Mantoux:	Date Tested: _____	Date Read: _____	Results: _____			
Lead Test:	Date Tested: _____	Lead Level: _____				
Influenza Vaccine: <i>(mandatory for pre-school students)</i>	1. _____ <i>mm/dd/yy</i>	2. _____ <i>mm/dd/yy</i>	3. _____ <i>mm/dd/yy</i>	4. _____ <i>mm/dd/yy</i>		
Pneumococcal Vaccine: <i>(mandatory for pre-school students)</i>	1. _____ <i>mm/dd/yy</i>					
Meningococcal Vaccine: <i>(mandatory for incoming Grade 6 students)</i>	1. _____ <i>mm/dd/yy</i>		2. _____ <i>mm/dd/yy</i>		3. _____ <i>mm/dd/yy</i>	
Other (specify):	_____					

Physician's Signature

Date