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 ☐M ☐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	LEAD SCREENING *(Not Required)*	
						TEST DATE	RESULT
DIPHTHERIA, TETANUS, PERTUSSIS (DTaP) or any combination (If Td or DT[1], indicate in corner box)							
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:					Exemptions: ☐ Medical Exemption Attached		
OTHER, SPECIFY:					☐ Religious Exemption Attached		

☐ 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
OCT 17

J1005

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