MOUNT ARLINGTON PUBLIC SCHOOL DISTRICT
MOUNT ARLINGTON PUBLIC SCHOOL
235 HOWARD BOULEVARD
MOUNT ARLINGTON, NEW JERSEY 07856
TELEPHONE: 973-398-4400 FAX: 973-398-5726

Student name_____ Date of birth_____

IMMUNIZATION REQUIREMENTS (K-8)

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

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

PROOF OF IMMUNIZATION

DTP _____ _____ _____ _____ _____ Tdap_____

Polio _____ _____ _____ _____ MMR _____ _____

Varicella _____ _____ Hepatitis B _____ _____ _____ _____

Meningococcal _____ Other_____

Printed Name/Address/Phone/Fax

_____ _____
Health Care Provider Signature Date