PROVISIONAL IMMUNIZATION ADMITTANCE REQUEST

Kindergarten – Grades 12

Provisional Admission allows a child to enter/attend school if they have a minimum of one dose of each of the required vaccines. (*See Physical Examination and Immunization Requirements*) Pupils must be actively in the process of completing the series. If a pupil is under five years of age, they have seventeen (17) months to complete the immunization requirements. If a pupil is five years of age and older, they have twelve (12) months to complete the immunization requirements.

Grace Periods

4-Day Grace Period: All vaccines doses administered *less than or equal to four days before* either the specified *minimum age or dose spacing interval* shall be counted as valid and shall not require revaccination in order to enter or remain in a school or preschool facility.

30-Day Grace Period: Those children *transferring into a New Jersey school* or preschool *from out of state/out of country* may be allowed a 30-day grace period in order to obtain past immunization documentation before provisional status shall begin.

To Be Completed By Parent

Name of Student _____

I request to have my child provisionally admitted to school pending the completion of the minimum immunization requirements. I affirm that the immunization required will be completed as soon as possible and in accordance with the appointment schedule provided by our family physician or local health department.

_____ _____ _____

Signature of Parent/Guardian *Date* *Telephone Number*

To Be Completed By Physician/Health Officer

The above pupil's immunization series has been initiated and she/he is in the process of complying with all the immunization requirements. I have arranged an appointment schedule and agree to provide the remaining immunizations.

All immunization requirements should be met by _____.

**Expiration of Provisional Admittance*

_____ _____

Name of Physician/Health Officer *Telephone Number*

_____

Address

_____ _____

Signature of Physician/Health Officer *Date*

_____

Stamp of Physician/Health Officer (Name/Address/Phone)

**May Not Exceed One (1) Year.*

1/2009
/dc