

GLEN ROCK MIDDLE SCHOOL HEALTH OFFICE

STEPHANIE NERNEY, RN, CSN

Phone: 201-445-7700 Ext: 8920

Fax: 201-389-5048

[Nerneys@glenrocknj.org](mailto:Nerneys@glenrocknj.org)

Dear Parents/Guardians:

*The following information explains that new immunizations must be given prior to start of 6<sup>th</sup> grade!*

This is a reminder informing you that the New Jersey Department of Health and Senior Services (DHSS) has recently revised the administrative rules with substantive changes to include the requirement of new vaccines for students attending **sixth** grade. The amended regulations state the following:

Every child born on or after January 1, 1997 and entering grade six on or after September 1, 2008 shall have received one (1) dose of Tdap given no earlier than the 10<sup>th</sup> birthday.

Children entering or attending grade six on or after September 1, 2008 who received a TD booster within the last 5 years shall not be required to receive a Tdap dose until five (5) years have elapsed from the last DTP/Tdap or Td injection.

Every child born on or after January 1, 1997 and entering or attending grade six on or after September 1, 2008 shall have received one (1) dose of a meningococcal-containing vaccine, such as the medically-preferred meningococcal conjugate vaccine.

Students MUST provide documentation of these immunizations from their primary care provider PRIOR TO the first day of school. The completed paperwork can be sent via mail addressed to Mrs. Nerney or dropped off at the Health Office during the summer collection dates for sports physicals. Dates will be posted on the Glen Rock Athletic website.

Please make a copy of your documents prior to submitting them. Please speak with your physician regarding any questions. If you need to contact me during the summer, please leave a message on my voicemail or e-mail and I will get back to you. Thank you for your cooperation in this matter.

Student Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

The above named student has received:

1. Tdap booster on \_\_\_\_\_  
Month/Day/Year

2. Meningococcal vaccine \_\_\_\_\_  
Month/Day/Year

Signature of Primary Provider

Print or Stamp of Primary Provider