Thomas Jefferson School
95 East Main Street
Rockaway, NJ 07866
973-625-8603

August 2023

Dear Parent/Guardian:

As you are already aware, the New Jersey Department of Health and Senior Services has mandated that children born after January 1997 and entering grade six must receive a booster dose of the Diphtheria, Tetanus Toxoids and Pertussis, (Tdap) vaccine as well as one dose of the Meningococcal vaccine.

Once your child has received these two immunizations, usually at their 11-year-old physical, you **must** have the student's Primary Healthcare Provider **write a note or complete the form below. The signature of the primary care provider and office stamp must be included.** Please be sure to **return via hand deliver, email or mail to the school nurse by August 14th, 2023. If you are unable to obtain these vaccines by August 14th, 2023 please know your child will still need to receive the vaccines before beginning grade 6 in September.**

If proof of these immunizations is not received by the first day of school in September 2023 the student will be **excluded from attending.**

If your child turns eleven (11) years old on or after the first day of school, you have four (4) days after your child's birthday to have your student immunized; therefore, the form is due the fifth (5th) day after the birthday. **Please make your child's physical appointment early in order to comply with the law.** If the form is not received on time, your child will be excluded from attending school until the proof of immunization is received at the Health Office.

Please contact Mrs. Linda Savercool, your school nurse if you have any questions.
Thank you for your cooperation in this important matter.

Mrs. Linda Savercool BSN, RN, CSN
Certified School Nurse

Student: _____ Birthdate_____

Grade_____ Homeroom Teacher _____

***According to the NJ Immunization requirements, the Tdap **must** be at least five years after the last dose of DTP, DTaP or Td.

The above named student has received:

1. Tdap booster on _____
2. Meningococcal on _____

Primary Care Provider Signature and Stamp _____

Date _____