MONTVILLE TOWNSHIP PUBLIC SCHOOLS
HEALTH SERVICES

Cedar Hill: extension 1010
Hilldale: extension 1210
Lazar Middle: extension 2315
Montville High: extension 2609 or 2610
Valley View: extension 1410
William Mason: extension 1610
Woodmont: extension 1810

February 3, 2020

Dear Parent/Guardian:

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 complete the form below, including the signature and office stamp. Please be sure to **return it to your school nurse by June 1, 2020.**

If proof of these immunizations is not received by the first day of school in September 2020, the student will be **excluded from attending Robert R. Lazar Middle School.**

If your child will turn eleven (11) during the summer months, please return this completed form during the summer, to the Robert R. Lazar Main Office. Please address it to the school nurses.

If your child will turn eleven (11) years old on or after the first day of school, you have four days after your child's birthday to have your student immunized; therefore, the form is due on the fifth 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 Lazar Health Office.

Thank you for your cooperation in this important matter.

Certified School Nurse

Student: _____ Birthdate: _____

Grade: _____ Teacher or Homeroom: _____

***According to 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 _____
   month, day, year

2. Meningococcal on _____
   month, day, year

Primary Care Provider Signature & Stamp _____