

Rainbow Montessori School
4 Madison Avenue
Madison, NJ 07940
973-377-0135

New Jersey State Department of Health
STANDARD SCHOOL / CHILD CARE CENTER IMMUNIZATION RECORD

Name: _____ Date of Birth _____ Sex _____

Parents Name: _____ Phone# _____

Street Address: _____

City, State, Zip: _____

Name of Doctor: _____ Phone# _____

Vaccine Type	Disease date	1st dose date	2nd dose date	3rd dose date	4th dose date	5th dose date
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Diphtheria,
Tetanus, Pertussis
DTP if DT indicate

Polio Oral
Polio Vaccine OPV if
Salk vaccine indicate

Measles, Mumps
Rubella (MMR)

or Measles Serology date titer

Measles

or Rubella Serology date titer

Rubella

or Mumps Serology date titer

Mumps

Chicken pox

Pneumococcal Conjugate

Haemophilus B HIB

Hepatitis B

Influenza Shot

Provisional Admission attached Date: _____ Medical Exempt: _____ Religious Exempt _____
I examined the above child and found him/her to be physically able to participate in all nursery school activities

Physician's signature: _____ Date _____

FAILURE TO COMPLY WITH STATE IMMUNIZATIONS REQUIREMENTS WILL PREVENT YOUR CHILD FROM ATTENDING SCHOOL.

HAS YOUR CHILD HAD THE CHICKEN POX? YES NO DATE