

Washington Township School District  
"Making a Difference"

Brass Castle School  
16 Castle St.  
Washington, NJ 07882  
908-689-1188  
Jessica L. Garcia, *Principal*

District Central Office  
Old Schoolhouse  
One East Front Street  
Washington, NJ 07882  
908-689-1119  
Keith T. Neuhs, *Superintendent*

Port Colden School  
30 Port Colden Rd.  
Washington, NJ 07882  
908-689-0681  
Michael J. Neu, *Principal*

June 20, 2017

Dear Parents/Guardians of current 5<sup>th</sup> grade students:

This is to inform you of the New Jersey Department of Health and Senior Services (DHSS) vaccine requirements for students attending sixth grade in September. The regulations state the following:

Every child born on or after January 1, 1997 and entering grade six on or after September 1, 2010 shall have received one (1) dose of Tdap (Tetanus, diphtheria, acellular pertussis) given no earlier than the 10<sup>th</sup> birthday.

Children entering or attending grade six on or after September 1, 2010 who received a Td booster dose less than five (5) years prior to entry or attendance shall not be required to receive a Tdap dose until five (5) years have elapsed from the last DTP/Dtap or Td dose.

Every child born on or after January 1, 1997 and entering or attending grade six on or after September 1, 2010 shall have received one (1) dose of a meningococcal-containing vaccine, such as the medically-preferred meningococcal conjugate vaccine.

Please submit a physician's signed statement showing proof of immunization showing the month, day and year of immunization. **Students will be excluded from school if this requirement has not been met by September 1**

If you have any questions regarding these new requirements, please feel free to contact me at (908)689-1188 ext. 3607. Thank you for your cooperation in this matter.

Sincerely,  
Brass Castle School Nurse

**Student Name:** \_\_\_\_\_

**Today's Date:** \_\_\_\_\_

**Grade:** \_\_\_\_\_

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

**The above-named student has received:**

1. **The Tdap booster on:** \_\_\_\_\_  
Month/Day/Year
2. **The Meningococcal vaccine on:** \_\_\_\_\_  
Month/Day/Year

\_\_\_\_\_  
**Signature of Primary Care Provider**

\_\_\_\_\_  
**Stamp of Primary Care Provider (REQUIRED)**

*Please return to the school nurse*