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*

August 9, 2017

Dear Parents/Guardians of current 6th 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 10th 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 August 31, 2017.**

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

Sincerely,
Brass Castle School Nurse

Student Name: _____ **Today's Date:** _____

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