JACKSON SCHOOL DISTRICT
151 Don Connor Boulevard
Jackson, NJ 08527
(732) 833-4600 FAX (732) 833-4609

*Nicole Pormilli, Superintendent of Schools*

Date: July 31, 2025
To: Parents and Guardians
Subject: Immunization Information

This letter reminds you about New Jersey state law regarding updated proof of immunizations for parents and guardians of students who will be in either PRESCHOOL, KINDERGARTEN, or SIXTH GRADE (or who will be 11 years old) during the 2025-2026 school year.

These laws took effect September 1, 2008 and apply to any current student or student who transfers into the Jackson School District. **ALL STUDENTS DESCRIBED ABOVE MUST HAVE RECEIVED THESE REQUIRED VACCINATIONS BY THE FIRST DAY OF SCHOOL. Failure to obtain these newly required immunizations will result in your child being EXCLUDED FROM SCHOOL AS OF OCT. 14, 2025 if the updated form is not received by Oct. 10, 2025** (with the exception of the preschool influenza vaccine deadline being Dec. 31, 2025)**.**

An immunization update form you can bring to your doctor is on the next page. If it is summertime, you may drop your immunization update form off during the summer at the main office of your child's school. If you have any questions about these requirements, please contact your school nurse. **www.jacksonsd.org/nurses.**

**For 6th grade parents:** The law requires students who obtain the following immunizations on or after their 11th birthday:

- One dose of Diptheria, Tetanus, Pertussis (Tdap) vaccine (updated 9-16-25)
- One dose of Meningococcal or Meningococcal Conjugate vaccine.

**For Kindergarten parents:** Any child entering the district's Kindergarten program (either general education or special education) must obtain the following immunizations:

- Diphtheria, Tetanus, Pertussis (DTap) vaccine, 4 doses with one dose after the 4th birthday or any 5 doses
- Polio vaccine, 3 doses with one dose after the 4th birthday or any 4 doses
- MMR vaccine, two doses
- Varicella vaccine, one dose

**For Preschool parents:** Any child entering the district's preschool inclusion program (either general education or special education) must obtain the following immunizations:

- Pneumococcal Conjugate Vaccine (PCV) – At least one dose of PCV after their first birthday.
- Influenza vaccine – One dose annually **between September 1 and December 31 of each year. You will need to submit proof of this immunization by Dec. 31, 2025.**

Your physician **MUST** stamp the form in order for it to be valid. The form should be dropped off at your child's school for the school nurse. These vaccines should be administered by your private physician.

**Failure to obtain these newly required immunizations will result in your child being EXCLUDED FROM SCHOOL AS OF OCT. 14, 2025 if the form is not received by if the updated form is not received by Oct. 10, 2025** (with the exception of the preschool influenza vaccine deadline being Dec. 31, 2025)**.**

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# Immunization Update Request

**Student: _____ School: _____ Grade: ____ Date: _____**

State Law mandates immunization of all students under Chapter 14, N.J. State Sanitary Code, **IMMUNIZATION OF PUPILS IN SCHOOL.** This law requires schools to take necessary steps for implementation. Among these immunizations are those that a child would not have yet had when they registered in our district. By law, we must show updated proof of these immunizations, which is done through this Immunization Update Form. This applies to parents of students who:

- Will enter our Preschool program, Kindergarten program or 6th grade during the 2025-2026 school year

**All students MUST have received these vaccinations by the first day of school. Failure to comply with this state requirement and submit this updated immunization form by Oct. 10, 2025 will result in your child's exclusion from school beginning Oct. 14, 2025.**

Please include **month/day/year**:

| | Month | Day | Year | Comment |
|---|---|---|---|---|
| DTaP | | | | |
| Tdap | | | | |
| Hepatitis B # 1 #2 #3 | | | | |
| Measles, Mumps, Rubella | | | | |
| MMR – Booster | | | | |
| Polio vaccine IPV | | | | |
| Tuberculin Test: _____ | | | | Result: |
| Varicella #1 #2 | | | | |
| Meningococcal | | | | |
| Pneumococcal #1 #2 #3 #4 | | | | |
| Influenza | | | | |
| Entry Physical | | | | |

This patient will return on _____for the next in series of immunizations.

**Physician's Name: _____**

**Office Address: _____**

**Physician's Signature and Stamp: _____**

**PARENTS: AFTER YOUR DOCTOR FILLS OUT THIS FORM, PLEASE RETURN IT TO YOUR SCHOOL NURSE.**