

RIDGEWOOD PUBLIC SCHOOLS  
Ridgewood, New Jersey

PROVISIONAL IMMUNIZATION ADMITTANCE REQUEST

Kindergarten – Grades 12

**Provisional Admission** allows a child to enter/attend school if they have a minimum of one dose of each of the required vaccines. (See *Physical Examination and Immunization Requirements*) Pupils must be actively in the process of completing the series. If a pupil is under five years of age, they have seventeen (17) months to complete the immunization requirements. If a pupil is five years of age and older, they have twelve (12) months to complete the immunization requirements.

**Grace Periods**

**4-Day Grace Period:** All vaccines doses administered *less than or equal to four days before* either the specified *minimum age or dose spacing interval* shall be counted as valid and shall not require revaccination in order to enter or remain in a school or preschool facility.

**30-Day Grace Period:** Those children *transferring into a New Jersey school or preschool from out of state/out of country* may be allowed a 30-day grace period in order to obtain past immunization documentation before provisional status shall begin.

**To Be Completed By Parent**

Name of Student \_\_\_\_\_

I request to have my child provisionally admitted to school pending the completion of the minimum immunization requirements. I affirm that the immunization required will be completed as soon as possible and in accordance with the appointment schedule provided by our family physician or local health department.

\_\_\_\_\_  
*Signature of Parent/Guardian*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Telephone Number*

**To Be Completed By Physician/Health Officer**

The above pupil's immunization series has been initiated and she/he is in the process of complying with all the immunization requirements. I have arranged an appointment schedule and agree to provide the remaining immunizations.

All immunization requirements should be met by \_\_\_\_\_.  
*\*Expiration of Provisional Admittance*

\_\_\_\_\_  
*Name of Physician/Health Officer*

\_\_\_\_\_  
*Telephone Number*

\_\_\_\_\_  
*Address*

\_\_\_\_\_  
*Signature of Physician/Health Officer*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Stamp of Physician/Health Officer (Name/Address/Phone)*

*\*May Not Exceed One (1) Year.*