

FLEMINGTON-RARITAN SCHOOL DISTRICT
SCHOOL HEALTH SERVICES
NOTICE TO PARENTS REGARDING IMMUNIZATION DEFICIENCIES

Date: _____

Dear Parent: _____
Student's Name _____ Grade _____

In order for a student **to enter and/or remain** in the Flemington/Raritan School District, the student must meet the immunization requirements as set forth by Chapter 14. NJ State Sanitary Code **amended December 14, 2007**.

OUR RECORDS INDICATE THAT YOUR CHILD NEEDS THE FOLLOWING VACCINE:

Vaccine Type		
Regulation 4:16	Influenza	

If you have documented immunization records, please attach to this form and return immediately to the School Health Office or contact your physician regarding these immunization deficiencies.

If you need financial assistance, contact the Hunterdon County Health Dept. Reduced Cost Childhood Vaccine Program, 806-4570.

Immunization must be completed by December 31st. Please return prior to the Winter Break.



Student's Name _____ Grade/Homeroom _____

This is to certify that the above student has received the following Influenza immunization:

Vaccine Brand: _____ Route: _____ Date given: _____

Signature of Physician _____ Telephone Number _____

Stamper/Address: _____

If you have any questions regarding the above letter, please call the Health Office at 284-7670.
