Veterans Memorial School

424 South Main Road ♦ Vineland, NJ 08360-7843 ♦ (856) 794-6918 ♦ Fax (856) 507-8759

Mrs. Hope Johnson
Principal

Ms. Dorothy Burke
Assistant Principal

Date:________________

Student:____________________________________
ID#____________________Grade__________HR______Date of Birth____________

Dear Parent/Guardian:

It has been brought to my attention that your child needs the following immunizations:

_____Hepatitis B #1 (HBV)
_____Hepatitis B #2 (HBV)
_____Hepatitis B #3 (HBV)
_____Haemophilus (Hib)
_____Measles, Mumps, Rubella #1 (MMR)
_____Measles, Mumps, Rubella #2 (MMR)
_____Polio
__✓__Diphtheria, Tetanus, Pertussis (DTP, TD, Tdap)
__✓__Meningitis

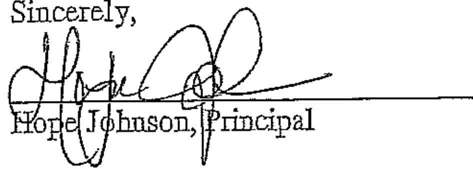
The immunization is due by September 5th, 2019 (1st day of school)

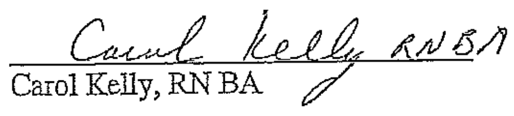
_____Until proof of this immunization from your doctor or health clinic is presented to the school nurse, your child is not permitted to attend school.

__✓__If your child does not receive the necessary immunization by 9/5/2019, he/she will not be permitted to attend school until the immunizations are received.

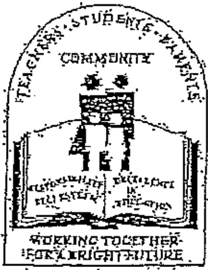
Thank you for your interest and cooperation.

Sincerely,


Hope Johnson, Principal


Carol Kelly, RN BA

Immunization given:________________Date given:____________
Doctor's Signature:____________________________________
Doctor's Stamp & Address



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Fecha:_______________

Estudiante:______________________________
ID#:_______________Grado______HR______Fecha da Nacimiento_______________

Estimado padre/encargado:

He notado que su hijo(a) necesita las siguientes vacunas:

_____Hepatitis B#1 (HBV)
_____Hepatitis B#2 (HBV)
_____Hepatitis B#3 (HBV)
_____Haemophilus (Hib)
_____Varicella
_____Sarampion, Papera, Rubeola #1 (MMR)
_____Sarampion, Papera, Rubeola #2 (MMR)
_____Polio
_____Difteria, Tetano, Petussis (DTP, Td, Tdap)
_____Meningitis

Por favor, haga que su hijo(a) reciba esta vacunas antes de_______________________

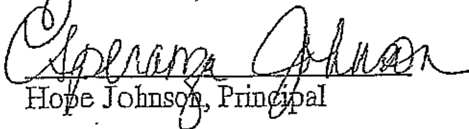
_____Su hijo(a) sera suspendido de la escuela hasta que usted present el certificado de vacunacio recibido de su medico o de la clinica de salud.

_____Si su hijo(a) no recibe las vacunas necesarias antes se la fecha mencionada arriba, el/ella ser suspendido de la escuela hasta que recibamos el comprobante.

Si usted ya ha hecho una cita para el futuro, aceptaremos la prueba de que tiene tal cita.

Gracias por su interes y cooperación.

Atentamente,


Hope Johnson, Principal

Carol Kelly, RN BA

Clase de vacuna_________________________Fecha_______________
Firma del medica______________________________
Doctor's stamp and address: