PEMBERTON TOWNSHIP SCHOOLS

Tony Trongone ***Superintendent of Schools***

Registration Requirements for Students

Please bring the following documents with you to registration:

1. Birth Certificate - Birth Certificate must have a raised seal on it.
2. Immunization record
3. Transfer card/transcripts and current report card if transferring from another state or district.
4. Proof of Residency
5. Online Pre-registration. Please print the confirmation page and bring with you.

Proof of Residency: Please provide four (4) forms (listed below) to demonstrate Residency.

1. Homeowners:

- One (1) - Property tax bills, deeds, contracts of sale, mortgages, township bills (water, sewer, trash etc.)
- Three (3)-Voter registrations, licenses, permits, financial account information, utility bills, delivery receipts, and other evidence of personal attachment to a particular location

2. Renters

- Lease
- Three (3)-Voter registrations, licenses, permits, financial account information, utility bills, delivery receipts, and other evidence of personal attachment to a particular location

3. Military Living on Fort Dix

- Housing authority permit or lease.
  NOTE: School Option for Military Personnel will be enforced.

4. Residing with a Pemberton Township Resident:

- Resident who owns the home must file an "Affidavit of Domicile" and proof of residency as a Homeowner.
- Residents who rent the home must provide a copy of their lease and an addendum by the landlord listing the additional person(s) living in the property.

5. Guardianship

- Please provide all court documents pertaining to educational and/or residential custody.

Phone: 609-893-8141 Ext. 1003 *Fax:* 609-894-0933 *E-mail:* ttrongone@pemb.org
Office: One Egbert Street, Pemberton New Jersey 08068 www.pemberton.k12.nj.us

PEMBERTON TOWNSHIP SCHOOLS

Tony Trongone ***Superintendent of Schools***

_____
Student's Name

I, _____, have been informed by the Pemberton Township
(residential parent/guardian)

School District that I can only register students in Pemberton Township Schools if I am a resident of Pemberton Township.

I am aware that any person who makes a false statement or permits false statements to be made for the purpose of allowing a non-resident student to attend Pemberton Township Schools, commits a disorderly persons offense pursuant to N.J. 18A: 38-1 and may be prosecuted by law.

I authorize Pemberton Township Schools to investigate and confirm any and all statements by me and used in the enrollment of the above student. If any information is false I am aware that enrollment in Pemberton Township Schools will be terminated.

A. By initialing I am stating:	***Initial one***
1. I am a resident of Pemberton Township	_____
2. I am temporarily residing in Pemberton Township with a resident	_____
B. By initialing I am stating that I am the:	***Initial one***
1. Parent/Guardian	_____
2. Parent and/or guardian with residential custody (documentation provided)	_____
3. Sole caretaker (non-parent/guardian) due to economic/family hardship	_____
C. By initialing I am stating that I understand:	***Initial***
1. Any change in residency or custody will be reported immediately	_____

_____ _____
Signature of Parent/Guardian Date

_____ _____
District Official Date

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Middle States Accredited
PTS
You can get there from here!

PEMBERTON TOWNSHIP SCHOOLS

JEFF HAVERS
Assistant Superintendent for Elementary
Preschool - 5th grade

TONY TRONGONE
Superintendent

Home Language Survey
Parent/Guardian Language Questionnaire

Name:_____ Age: _____
[first] [middle] [last]
Date of School Entrance_____

Person completing the survey: [ ] Mother [ ] Father [ ] Grandparent
[ ] Guardian [ ] Other _____

Directions: Check or write in the correct response for each of the following questions about your child.

1. What is the primary language did your child learn when he/she first began to talk?

   English_____ Other [specify]_____

2. What language does the family speak at home most of the time?

   English_____ Other [specify]_____

3. What language does the parent [guardian] speak to the child most of the time?

   English_____ Other [specify]_____

4. What language does the child speak to his/her parent [guardian] most of the time?

   English_____ Other [specify]_____

5. What language does the child speak to her/her brothers and sisters most of the time?

   English_____ Other [specify]_____

6. What language does the child speak to his/her friends most of the time?

   English_____ Other [specify]_____

7. In which language do you wish to receive school communication?

   English_____ Other [specify]_____

Signature:_____ Date:_____
[person completing the survey]

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PEMBERTON TOWNSHIP SCHOOLS

JEFF HAVERS
Assistant Superintendent for Elementary
Preschool - 5th grade

TONY TRONGONE
Superintendent

Encuesta del Idioma usado en el Hogar
Idioma de Padres/Guardianes

Nombre: _____ Edad: _____
[Nombre] [Inicial] [Apellido]

Fecha de la entrada a la escuela: _____

Persona que completa la Encuesta: [ ] Madre [ ] Padre [ ] Abuelo(a)
[ ] Guardián [ ] Otro: _____

Direcciones: Seleccione o escriba la respuesta correcta para cada una de las siguientes preguntas acerca de su hijo.

1. ¿Que idioma aprendió su hijo(a) cuando empezó a hablar por primera vez?

   Ingles: [ ] Español: [ ] Otro [Especifique cual]: _____

2. ¿Que idioma se habla en su hogar la mayoría del tiempo?

   Ingles: [ ] Español: [ ] Otro [Especifique cual]: _____

3. ¿Que idioma le habla ustedes al niño(a) la mayoría del tiempo?

   Ingles: [ ] Español: [ ] Otro [Especifique cual]: _____

4. ¿Que idioma habla el niño(a) con ustedes la mayoría del tiempo?

   Ingles: [ ] Español: [ ] Otro [Especifique cual]: _____

5. ¿Que idioma le habla el niño(a) a sus hermanos(as) la mayoría del tiempo?

   Ingles: [ ] Español: [ ] Otro [Especifique cual]: _____

6. ¿Que idioma habla el niño(a) a sus amigos la mayoría del tiempo?

   Ingles: [ ] Español: [ ] Otro [Especifique cual]: _____

7. ¿En que idioma desea recibir comunicados de la escuela?

   Ingles: [ ] Español: [ ] Otro [Especifique cual]: _____

Firma: _____ Fecha: _____
[Persona que lleno la encuesta]

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Pemberton Township School District

STUDENT MEDICAL HISTORY

Since the health of a child can affect his/her ability to learn in school, please assist our school personnel in providing the following information:

Student Name_____ Birthdate _____ M ___ F ___

CURRENT HEALTH INFORMATION - please answer all the following questions by circling Yes or No

Y	N	Is your child now under the care of a physician for a medical or surgical problem?
Y	N	Does your child have any physical limitations or restrictions?

Has your child ever experienced any of the following?

Circle one			*If yes, indicate date, details, and medication*
Y	N	Asthma	
Y	N	ADD or ADHD (circle one)	
Y	N	Medication allergy or sensitivity (circle one)	
Y	N	Bee sting- allergy or sensitivity (circle one)	
Y	N	Food allergy or sensitivity (circle one)	
Y	N	Diabetes	
Y	N	Frequent ear infections	
Y	N	Frequent bladder or kidney infections	
Y	N	Frequent nose bleeds	
Y	N	Seizure disorder	
Y	N	Headaches	
Y	N	High blood pressure	
Y	N	Heart conditions	
Y	N	Concussion / head injury requiring medical treatment	
Y	N	History of fainting with exercise	
Y	N	Operations (not stitches for lacerations)	
Y	N	Fractures (broken bones) or dislocations	
Y	N	Speech problems	
Y	N	Mental health concerns	
Y	N	Need for hearing aide/implant/ear tubes/hearing concerns	
Y	N	Wears glasses and/or contact lenses/vision concerns	
Y	N	Any chronic/serious illness not mentioned above	
Y	**N**	***Medication at home or in school**	

**If medication is needed in school it MUST be brought to the health office in the original container with a physician's order. The child's parent/guardian is required to complete the Student Medication Permission form. Medication orders MUST be renewed EVERY year or participation in ANY activities (after school, field trips etc.) will be denied.*

Y	**N**	****Tylenol/Acetaminophen or Motrin/Ibuprofen given by the nurse every 4-6 hours**

***Our school physician has written orders for the nurse to give the recommended OTC manufacturer's dosage of Tylenol/acetaminophen or Motrin/ibuprofen every 4-6 hours as needed for pain/fever with your permission as per nurse's assessment. By signing this form you hereby release the Pemberton Township BOE and all school District personnel from liability.*

I understand that relevant information regarding my child's health may be shared with the appropriate school personnel and other health care providers as necessary. In case of serious illness or injury, I request that the school contact me or the physician named. If neither is available, I give the school permission to make all necessary arrangements to obtain emergency care for my child including taking my child to the hospital. I will also call the school when my child is absent.

Signature: _____ Date: _____

Home Phone: _____ Cell Phone: _____

Doctor's Name: _____ Dr.'s Phone: _____

Pemberton Township Schools
Student Health History Questionnaire

Today's date: _____

Person completing this form: _____

Relationship to child: _____

GENERAL INFORMATION {please print}

Student's Full Name: _____

Date of Birth: _____ Age: _____ Grade: _____

Sex: ☐ Male or ☐ Female {check box}

Parent/Guardian Name:	Parent/Guardian Name:
Current Address:	Current Address:

How long at this address: _____ Language(s) spoken at home_____

Who lives in your household: _____

Home Phone Number: _____ Cell Phone Number: _____

Sibling Name: _____ DOB: _____

Sibling Name: _____ DOB: _____

Sibling Name: _____ DOB: _____

Sibling Name: _____ DOB: _____

Name of Previous School: _____

Address: _____

Is your child: ☐ Biological Child ☐ Adopted Child ☐ Foster Child ☐ Other _____

Child's Physician's Name: _____ Phone Number_____

Physician's Address: _____

II. HEALTH HISTORY - {please check box and provide explanation for only checked responses}

- ☐ Chicken Pox Explain: _____
- ☐ Strep Throat/Infections Explain: _____
- ☐ Lyme Disease Explain: _____
- ☐ Ear Infections Explain: _____
- ☐ Asthma Explain: _____
- ☐ Headaches Explain: _____
- ☐ Heart Problems Explain: _____
- ☐ Serious Allergies Explain: _____
- ☐ Food Allergies Explain: _____
- ☐ Drug Allergies Explain: _____
- ☐ Life Threatening Allergies Explain: _____
- ☐ Chronic Illnesses Explain: _____

(diabetes, cystic fibrosis, muscular dystrophy, kidney disease, cancer, metabolic disorders, etc.)

- ☐ Speech Problems Explain: _____
- ☐ Hearing Problems Explain: _____
- ☐ Vision Problems Explain: _____
- ☐ Seizures Explain: _____
- ☐ Orthopedic Problems Explain: _____
- ☐ Birth Defects Explain: _____
- ☐ Serious Illness or Accident Explain: _____
- ☐ Hospitalization or Surgery Explain: _____
- ☐ Bowel or Bladder Problems Explain: _____
- ☐ Adaptive aids Explain: _____

(glasses, hearing aid, wheelchair, braces, etc.)

Please check appropriate box below for conditions that describe the health of the child & mother during…

Mother's Pregnancy	Child's Delivery	Child's Condition at Birth
☐ No complications	☐ Normal	☐ Normal
☐ Blackouts	☐ Induced labor	☐ Lack of oxygen
☐ Falls	☐ C-section	☐ Breathing problem
☐ Physical injury	☐ Breech birth	☐ Birth injury/defect
☐ Excessive bleeding	☐ Unusually long labor (>12 hours)	☐ Jaundice
☐ Hypertension	☐ Premature # of weeks _____	☐ Newborn ICU # of days _____
☐ Diabetes	☐ Overdue # of weeks _____	☐ Other problem (specify) _____
☐ Emotional stress	☐ Other problem (specify)	
☐ Toxemia	_____	
☐ Alcohol and/or drug use	_____	
☐ Use of tobacco	_____	

III. CURRENT HEALTH/DEVELOPMENTAL STATUS

1. Describe the state of your child's current health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor
2. Is your child currently taking any medication? ☐Yes ☐ No
   If yes, please list medications and uses: _____
   _____
3. If need be, would you have any objection to your child being placed in a peanut/ tree nut safe classroom? ☐Yes ☐ No
4. Does your child sleep in his/her own bed? ☐Yes ☐ No
5. Does your child share a room with anyone else? ☐Yes ☐ No
6. Does your child use toilet independently? ☐Yes ☐ No
   If no, describe assistance needed: _____
7. Are there any problems which might affect your child's learning? ☐Yes ☐ No
   If yes, describe: _____
8. Has your child received any type of therapy (i.e., counseling, speech therapy, physical therapy, occupational therapy, vision therapy, etc.) ☐Yes ☐ No
   If yes, describe: _____

9. Has your child ever had trouble walking, climbing, reaching, holding on to things?
   □Yes □ No If yes, describe: _____

10. At what age did your child …?
    - Sit up on his/her own _____
    - Crawl _____
    - Walk _____
    - Speak using single words _____
    - Speak using 2-3 word sentences _____

11. Can your child speak so that he/she can be understood by others? □Yes □ No

12. Do you have concerns about your child's willingness to try different foods?
    □Yes □ No If yes, describe: _____

13. Does your child sleep in his/her own bed? □Yes □ No

14. What time is your child's normal bedtime? _____

15. What time is your child's normal wake up time? _____

16. Do you have concerns about your child's sleeping patterns? □Yes □ No
    If yes, describe: _____

17. Is your child highly active? □Yes □ No

18. Is your child very quiet? □Yes □ No

19. Does your child talk with your friends/relatives who visit? □Yes □ No

20. Does your child have opportunities to play with other children? □Yes □ No

21. Any other information that you want to share? □Yes □ No
    If yes, describe: _____

****PLEASE RETURN THIS FORM TO THE SCHOOL NURSE****

PEMBERTON TOWNSHIP SCHOOLS

Tony Trongone ***Superintendent of Schools***

Dear Parent/Guardian,

The New Jersey Department of Education code states that each student's medical examination shall be conducted at the "medical home" (family physician) and recorded on a form supplied by the school. If the student does not have a "medical home" (family physician), the district shall provide this examination at the school's physician's office or other appropriate facility. Southern Jersey Family Medical Center performs physicals and other medical services. You can make an appointment by calling 1-800-486-0131. A student's "medical home" is defined as a health care provider and that provider's practice site is chosen by the student's parent or guardian for the provision of health care.

Each student shall be examined as REQUIRED below:

1. All students ages 3-5 upon initial entrance to school (initial entrance may be pre-school or kindergarten within the state of New Jersey.

2. All new students from out-of-state within 30 days of entry.

3. Student's participation in sports (Intramural and Interscholastic) grades 6-12. Please see your School Nurse for the specific form that must be used or download it from the district website.

   *(A student transferring in from outside of the United States may need to be tested for tuberculosis. Your child's School Nurse will notify you if this applies to your child.)

It is recommended that subsequent physicals be done:

1. Pursuant to a comprehensive Child Study Team evaluation, if recommended.

2. During the student's pre-adolescence fourth through sixth grade.

3. During adolescent (7^{th} through 12^{th} grade).

If you do not have a medical provider (family physician) for your child, please contact your school nurse for information. Thank you for your cooperation.

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Office: One Egbert Street, Pemberton New Jersey 08068 www.pemberton.k12.nj.us

UNIVERSAL
CHILD HEALTH RECORD

Endorsed by: *American Academy of Pediatrics, New Jersey Chapter*
New Jersey Academy of Family Physicians
New Jersey Department of Health

SECTION I - TO BE COMPLETED BY PARENT(S)

Child's Name *(Last)* *(First)*	Gender ☐ Male ☐ Female	Date of Birth / /
Does Child Have Health Insurance? ☐Yes ☐No	If Yes, Name of Child's Health Insurance Carrier	
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number
Parent/Guardian Name	Home Telephone Number	Work Telephone/Cell Phone Number

I give my consent for my child's Health Care Provider and Child Care Provider/School Nurse to discuss the information on this form.

Signature/Date	This form may be released to WIC. ☐Yes ☐No

SECTION II - TO BE COMPLETED BY HEALTH CARE PROVIDER

Date of Physical Examination:	Results of physical examination normal? ☐Yes ☐No

Abnormalities Noted:	Weight *(must be taken within 30 days for WIC)*	
	Height *(must be taken within 30 days for WIC)*	
	Head Circumference *(if <2 Years)*	
	Blood Pressure *(if ≥3 Years)*	

IMMUNIZATIONS	☐ Immunization Record Attached ☐ Date Next Immunization Due:

MEDICAL CONDITIONS

Chronic Medical Conditions/Related Surgeries • List medical conditions/ongoing surgical concerns:	☐ None ☐ Special Care Plan Attached	Comments
Medications/Treatments • List medications/treatments:	☐ None ☐ Special Care Plan Attached	Comments
Limitations to Physical Activity • List limitations/special considerations:	☐ None ☐ Special Care Plan Attached	Comments
Special Equipment Needs • List items necessary for daily activities	☐ None ☐ Special Care Plan Attached	Comments
Allergies/Sensitivities • List allergies:	☐ None ☐ Special Care Plan Attached	Comments
Special Diet/Vitamin & Mineral Supplements • List dietary specifications:	☐ None ☐ Special Care Plan Attached	Comments
Behavioral Issues/Mental Health Diagnosis • List behavioral/mental health issues/concerns:	☐ None ☐ Special Care Plan Attached	Comments
Emergency Plans • List emergency plan that might be needed and the sign/symptoms to watch for:	☐ None ☐ Special Care Plan Attached	Comments

PREVENTIVE HEALTH SCREENINGS

Type Screening	Date Performed	Record Value	Type Screening	Date Performed	Note if Abnormal
Hgb/Hct			Hearing		
Lead: ☐ Capillary ☐ Venous			Vision		
TB (mm of Induration)			Dental		
Other:			Developmental		
Other:			Scoliosis		

☐ ***I have examined the above student and reviewed his/her health history. It is my opinion that he/she is medically cleared to participate fully in all child care/school activities, including physical education and competitive contact sports, unless noted above.***

Name of Health Care Provider (Print)	Health Care Provider Stamp:
Signature/Date	

New Jersey Department of Health
MINIMUM IMMUNIZATION REQUIREMENTS FOR SCHOOL ATTENDANCE IN NEW JERSEY
N.J.A.C. 8:57-4: IMMUNIZATION OF PUPILS IN SCHOOL

Disease(s)	Meets Immunization Requirements	Comments
DTaP//DTP	**Age 1-6 years:** 4 doses, with one dose given on or after the 4th birthday, OR any 5 doses. **Age 7-9 years:** 3 doses of Td or any previously administered combination of DTP, DTaP, and DT to equal 3 doses	Any child entering pre-school, and/or pre-Kindergarten needs a minimum of 4 doses. A booster dose is needed on or after the fourth birthday, to be in compliance with Kindergarten attendance requirements. Pupils after the seventh birthday should receive adult type Td. Please note: there is no acceptable titer test for pertussis.
Tdap	**Grade 6** (or comparable age level for special education programs): 1 dose	For pupils entering Grade 6 on or after 9-1-08 and born on or after 1-1-97. A child is not required to have a Tdap dose until FIVE years after the last DTP/DTaP or Td dose.
Polio	**Age 1-6 years**: 3 doses, with one dose given on or after the 4th birthday, OR any 4 doses. **Age 7 or Older:** Any 3 doses	Any child entering pre-school, and/or pre-Kindergarten needs a minimum of 3 doses. A booster dose is needed on or after the fourth birthday to be in compliance with Kindergarten attendance requirements. Either Inactivated polio vaccine (IPV) or oral polio vaccine (OPV) separately or in combination is acceptable. Polio vaccine is not required of pupils 18 years or older.*
Measles	If born before 1-1-90, 1 dose of a live measles-containing vaccine on or after the first birthday. If born on or after 1-1-90, 2 doses of a live measles-containing vaccine on or after the first birthday.	Any child over 15 months of age entering child care, pre-school, or pre-Kindergarten needs a minimum of 1 dose of measles vaccine. Any child entering Kindergarten needs 2 doses. Intervals between first and second measles-containing vaccine doses cannot be less than 1 month. Laboratory evidence of immunity is acceptable.**
Rubella and Mumps	1 dose of live mumps-containing vaccine on or after the first birthday. 1 dose of live rubella-containing vaccine on or after the first birthday	Any child over 15 months of age entering child care, pre-school, or pre-Kindergarten needs 1 dose of rubella and mumps vaccine. Any child entering Kindergarten needs 1 dose each. Laboratory evidence of immunity is acceptable. **
Varicella	1 dose on or after the first birthday	All children 19 months of age and older enrolled into a child care/pre-school center after 9-1-04 or children born on or after 1-1-98 entering the school for the first time in Kindergarten or Grade 1 need 1 dose of varicella vaccine. Laboratory evidence of immunity, physician's statement or a parental statement of previous varicella disease is acceptable.
Haemophilus influenzae B (Hib)	**Age 2-11 Months**: 2 doses **Age 12-59 Months**: 1 dose	Mandated only for children enrolled in child care, pre-school, or pre-Kindergarten: Minimum of 2 doses of Hib-containing vaccine is needed if between the ages of 2-11 months. Minimum of 1 dose of Hib-containing vaccine is needed after the first birthday. ***
Hepatitis B	**K-Grade 12**: 3 doses or **Age 11-15 years**: 2 doses	If a child is between 11-15 years of age and has not received 3 prior doses of Hepatitis B then the child is eligible to receive 2-dose Hepatitis B Adolescent formulation.
Pneumococcal	**Age 2-11 months**: 2 doses **Age 12-59 months**: 1 dose	Mandated only for children enrolled in child care, pre-school, or pre-Kindergarten: Minimum of 2 doses of pneumococcal conjugate vaccine is needed if between the ages of 2-11 months. Minimum of 1 dose of pneumococcal conjugate vaccine is needed after the first birthday. ***
Meningococcal	Entering Grade 6 (or comparable age level for Special Ed programs): 1 dose	For pupils entering Grade 6 on or after 9-1-08 and born on or after 1-1-97. *** This applies to students when they turn 11 years of age and attending Grade 6.
Influenza	**Ages 6-59 Months**: 1 dose annually	For children enrolled in child care, pre-school, or pre-Kindergarten on or after 9-1-08. 1 dose to be given between September 1 and December 31 of each year. Students entering school after December 31 up until March 31 must receive 1 dose since it is still flu season during this time period.

New Jersey Department of Health

MINIMUM IMMUNIZATION REQUIREMENTS FOR SCHOOL ATTENDANCE IN NEW JERSEY
N.J.A.C. 8:57-4: IMMUNIZATION OF PUPILS IN SCHOOL

*** Footnote**: The requirement to receive a school entry booster dose of DTP or DTaP after the child's 4th birthday shall not apply to children while in child care centers, preschool or pre-kindergarten classes or programs.

The requirement to receive a school entry dose of OPV or IPV after the child's 4th birthday shall not apply to children while in child care centers, preschool or pre-kindergarten classes or programs.

**** Footnote**: Antibody Titer Law (Holly's Law)—This law specifies that a titer test demonstrating immunity be accepted in lieu of receiving the second dose of measles-containing vaccine. The tests used to document immunity must be approved by the U.S. Food and Drug Administration (FDA) for this purpose and performed by a laboratory that is CLIA certified.

***** Footnote**: No acceptable immunity tests currently exist for Haemophilus Influenzae type B, Pneumococcal, and Meningococcal.

Please Note The Following:

The specific vaccines and the number of doses required are intended to establish the minimum vaccine requirements for child-care center, preschool, or school entry and attendance in New Jersey. These intervals are not based on the allotted time to receive vaccinations. The intervals indicate the vaccine doses needed at earliest age at school entry. Additional vaccines, vaccine doses, and proper spacing between vaccine doses are recommended by the Department in accordance with the guidelines of the American Academy of Pediatrics (AAP) and Advisory Committee on Immunization Practices (ACIP), as periodically revised, for optimal protection and additional vaccines or vaccine doses may be administered, although they are not required for school attendance unless otherwise specified.

Serologic evidence of immunity (titer testing) is only accepted as proof of immunity when no vaccination documentation can be provided or prior history is questionable. It cannot be used in lieu of receiving the full recommended vaccinations.

Provisional Admission:
Provisional admission allows a child to enter/attend school after having received a minimum of one dose of each of the required vaccines. Pupils must be actively in the process of completing the series. Pupils <5 years of age, must receive the required vaccines within 17 months in accordance with the ACIP recommended minimum vaccination interval schedule. Pupils 5 years of age and older, must receive the required vaccines within 12 months in accordance with the ACIP recommended minimum vaccination interval schedule.

Grace Periods:

- 4-day grace period: All vaccine 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, pre-school, or child care facility.
- 30-day grace period: Those children transferring into a New Jersey school, pre-school, or child care center 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.