CHAPTER 57

COMMUNICABLE DISEASES

Authority

N.J.S.A. 26:1A–7, 26:4–1, 26:5C–5 et seq.

Source and Effective Date

R.1995 d.240, effective April 12, 1995.
See: 27 N.J.R. 420(a), 27 N.J.R. 1987(a).

Executive Order No. 66(1978) Expiration Date

Chapter 57, Communicable Diseases, expires April 12, 2000.

Chapter Historical Note

All provisions of this chapter became effective prior to September 1, 1969. Chapter 57 was amended by R.1984 d.121, effective May 20, 1984. See: 6 N.J.R. 140(a), 6 N.J.R. 241(c). Subchapter 4, Immunization of Pupils in School, was adopted as R.1975 d.121, effective May 16, 1975. See: 7 N.J.R. 154(a), 7 N.J.R. 264(a). Subchapter 5, Confinement of Persons With Tuberculosis, was adopted as R.1976 d.315, effective October 8, 1976. See: 8 N.J.R. 513(a). Chapter 57 was amended by R.1977 d.467, effective December 13, 1977. See: 10 N.J.R. 12(a); R.1978 d.244, effective July 24, 1978. See: 10 N.J.R. 246(b), 10 N.J.R. 334(a); R.1979 d.244, effective September 1, 1979. See: 10 N.J.R. 246(b), 10 N.J.R. 334(a); R.1978 d.293, effective October 1, 1978. See: 10 N.J.R. 146(a), 10 N.J.R. 358(b). Pursuant to Executive Order No. 66(1978), Subchapter 1, Reportable Communicable Diseases, was readopted as R.1980 d.498, effective November 12, 1980. See: 12 N.J.R. 577(e), 13 N.J.R. 13(b). Chapter 57 was amended by R.1981 d.502, effective January 4, 1982. See: 13 N.J.R. 738(a), 14 N.J.R. 45(c). Pursuant to Executive Order No. 66(1978), Subchapter 4, Immunization of Pupils in School, was readopted as R.1983 d.311, effective July 18, 1983. See: 15 N.J.R. 781(a), 15 N.J.R. 1253(a). Chapter 5 was amended by emergency R.1985 d.40, effective January 22, 1985. See: 17 N.J.R. 483(a). Section 8:57–4.16, Providing immunization, was readopted as R.1985 d.195, effective March 25, 1985. See: 17 N.J.R. 483(a), 17 N.J.R. 955(a). Chapter 57 was amended by R.1985 d.264, effective June 3, 1985. See: 17 N.J.R. 483(a), 17 N.J.R. 1414(a). Pursuant to Executive Order No. 66(1978), Subchapter 1, Reportable Communicable Diseases, was readopted as R.1985 d.363, effective June 18, 1985 (amendments effective July 15, 1985). See: 17 N.J.R. 784(a), 17 N.J.R. 1764(a). Subchapter 6, Cancer Registry, was adopted as R.1986 d.277, effective June 16, 1986. See: 17 N.J.R. 2836(b), 18 N.J.R. 1283(a). Subchapter 6, Cancer Registry, was recodified as Chapter 57A, Cancer Registry, by R.1990 d.242, effective May 21, 1990. See: 21 N.J.R. 3909(a), 22 N.J.R. 1596(a).

Pursuant to Executive Order No. 66(1978), Chapter 57 was readopted as R.1990 d.243, effective April 20, 1990. As a part of R.1990 d.243, Subchapter 2, Isolation of Persons Ill or Infected with a Communicable Disease, and Subchapter 3, Poliomyelitis Vaccine Records, were repealed, effective June 4, 1990. See: 21 N.J.R. 3897(a), 22 N.J.R. 1766(a). Subchapter 2, Reporting of Acquired Immunodeficiency Syndrome and Infection with Human Immunodeficiency Virus, was adopted as R.1990 d.244, and Subchapter 3, Reportable Occupational and Environmental Diseases and Poisons, was adopted as R.1990 d.245, effective May 21, 1990 (operative June 4, 1990). See: 21 N.J.R. 3905(a), 22 N.J.R. 1592(a); 21 N.J.R. 3907(a), 22 N.J.R. 1595(a).

Pursuant to Executive Order No. 66(1978), Chapter 57 was readopted as R.1995 d.240, effective April 12, 1995. See: Source and Effective Date.

Cross References

Blind and visually impaired services case management of clients with communicable diseases, see N.J.A.C. 10:91–5.7.

CHAPTER TABLE OF CONTENTS

SUBCHAPTER 5. CONFINEMENT OF PERSONS WITH TUBERCULOSIS

SUBCHAPTER 6. HIGHER EDUCATION IMMUNIZATION

SUBCHAPTER 7. STUDENT HEALTH INSURANCE COVERAGE

SUBCHAPTER 8. CHILDHOOD IMMUNIZATION INSURANCE COVERAGE

SUBCHAPTER 1. REPORTABLE COMMUNICABLE DISEASES

Source and Effective Date

R.1995 d.277, effective June 5, 1995.
See: 27 N.J.R. 420(a), 27 N.J.R. 2216(a).

8:57–1.1 Purpose and scope

(a) The purpose of this subchapter is to expedite the reporting of certain diseases or outbreaks of disease so that appropriate action can be taken to protect the public health. The latest edition of the American Public Health Association's publication, "Control of Communicable Disease in Man," should be used as a reference, providing guidelines for the characteristics and control of communicable diseases, unless other guidelines are issued by the Department.

(b) For purposes of research, surveillance, and/or in response to technological developments in disease detection or control, the Commissioner, or his or her designee, is empowered to amend the diseases specified in this subchapter for such periods of time as may be necessary to control disease, in accordance with the Administrative Procedure Act, N.J.S.A. 52:14B–1 et seq.

Amended by R.1990 d.243, effective June 4, 1990.
See: 21 N.J.R. 3897(a), 22 N.J.R. 1766(a).
Purpose and scope text separated from Foreword; balance of Foreword deleted.

8:57–1.2 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise.

"Child care center" means any home or facility required to be licensed by the Department of Human Services which is maintained for the care, development, or supervision of six or more children under six years of age who attend for less than 24 hours a day.

"Commissioner" means the New Jersey State Commissioner of Health.

"Communicable disease" means an illness due to a specific infectious agent or its toxic products which arises through transmission of that agent or its products from an infected person, animal, or inanimate reservoir to a susceptible host, either directly or indirectly through an intermediate plant or animal host, vector, or the inanimate environment.

"Department" means the New Jersey State Department of Health.

"Health officer" means a holder of a license as health officer issued by the State Department of Health, pursuant to N.J.S.A. 26:1A–38 et seq., who is employed by a local board of health to function during all working hours of the regularly scheduled work week of the governmental unit to which the local health agency is attached and not regularly employed during the working hours of that scheduled work week in other activities for which he or she receives remuneration.

"Health care provider" means a person who is directly involved in the provision of health care services, such as the clinical diagnosis and prescribing of medications, and when required by State law, the individual has received professional training in the provision of such services and is licensed or certified for such provision. This includes physicians, physician assistants, and nurse practitioners.

"Hospital" means an institution, whether operated for profit or not, which maintains and operates facilities for the diagnosis, treatment, or care of two or more non-related individuals suffering from illness, injury or deformity and where emergency, out-patient, surgical, obstetrical, convalescent, or other medical and nursing care is rendered for periods exceeding 24 hours.

"Local health department" means the board of health of a region or municipality or the boards, bodies, or officers in such region or municipality lawfully exercising any of the powers of a local board of health under the laws governing such region or municipality.

"May" means that the action referred to is discretionary.

"N.J.A.C." means the New Jersey Administrative Code.

"N.J.S.A." means the New Jersey Statutes Annotated.

"Nosocomial infection" means an infection occurring in a patient in a hospital or other health care facility and in whom it was not present or incubating at the time of admission, or the residual of an infection acquired during a previous admission. This term includes infections acquired in the hospital but appearing after discharge, and also such infections among the staff of the facility.

"Outbreak" means any unusual occurrence of disease or any disease above background or endemic levels. Endemic level refers to the usual prevalence of a given disease within a geographic area.

1. "Suspected outbreak" means an outbreak which appears to meet the definition of an outbreak, but has not yet been confirmed.

"Outpatient-based setting" means a setting in which preventive, diagnostic, and treatment services are provided to persons who come to the facility to receive services and depart from that facility the same day. This term includes, but is not limited to, private physicians offices, health maintenance organizations, clinics, public health centers, diagnostic centers, and treatment centers.

"Pediatric surveillance system" means a group of primary care pediatricians and family practice physicians who report weekly or monthly to the Department the number of patient diagnoses made in their practice by disease code.

"School" means any building, structure, or part thereof used for purposes of the education of children between grades kindergarten through 12 whether publicly or privately owned.

"Shall" means that the action referred to is mandatory.

"Venereal disease" means syphilis, gonorrhea, chancroid, lymphogranuloma venereum, and granuloma inguinal.

Amended by R.1990 d.243, effective June 4, 1990.
See: 21 N.J.R. 3897(a), 22 N.J.R. 1766(a).
Text of 1.2, reportable diseases, recodified to 1.3; text of 1.1, Definitions, recodified to 1.2 with reporting officer deleted; exception deleted at "State Department of Health."

8:57–1.3 Diseases which are immediately reportable

(a) The following diseases shall be reported immediately to the health officer:

1. Botulism *(Clostridium botulinum);*
2. Diphtheria *(Corynebacterium diphtheriae);*
3. *Haemophilus influenzae, invasive disease*;
4. Hepatitis A, institutional settings;
5. Measles;
6. Meningococcal disease (*Neisseria meningitidis*);
7. Pertussis (whooping cough, *Bordetella pertussis*);
8. Plague *(Yersinia pestis*);
9. Poliomyelitis;
10. Rabies (human illness);
11. Rubella;
12. Viral hemorrhagic fevers, including, but not limited to, Ebola, Lassa, and Marburg viruses;
13. Foodborne intoxications, including, but not limited to, ciguatera, paralytic shellfish poisoning, scombroid, or mushroom poisoning; and
14. Any foodborne, waterborne, nosocomial, outbreak or suspected outbreak or any outbreak or suspected outbreak of unknown origin.

(b) A health care provider, a chief executive officer or other person having control or supervision over a hospital, a laboratory director, an institutional superintendent, a child care center or preschool director, or a principal having knowledge of any person who is ill or infected with any disease listed in (a) above, or any communicable disease, whether confirmed or presumed, shall immediately report the facts by telephone to the health officer of the jurisdiction wherein the diagnosis is made. Such telephone report shall be followed up by a written or electronic report within 24 hours of the initial report. If the health officer is unavailable, the report shall be made to the Department by telephone (609–588–7500, during business hours; 609–392–2020, after business hours, on weekends and holidays) or by fax (609–588–7431).

As amended, R.1983 d.67, effective March 7, 1983.
See: 14 N.J.R. 1277(a), 15 N.J.R. 338(b).
Added Pneumocystis carinii Pneumonia and Toxic Shock Syndrome. Also amended Lyme Arthritis to Lyme Disease.
Amended by R.1985 d.363, effective July 15, 1985.
See: 17 N.J.R. 784(a), 17 N.J.R. 1764(a).
Added "Meningitis" to the list of reportable diseases.
Amended by R.1990 d.243, effective June 4, 1990.
See: 21 N.J.R. 3897(a), 22 N.J.R. 1766(a).
Text of 1.3, reporting of diseases by physicians, recodified to 1.4; text on reportable diseases recodified from 1.2 to 1.3; with specified diseases to be reported in writing to the Department by expanded list of professionals; exceptions for specified diseases noted; many revisions to lists in (a) and (b); and new (c) and (e) added.

Cross References

Personal care homes, records documenting contagious diseases contracted by employees as under this section, see N.J.A.C. 8:36–16.4.

Statutory References

N.J.S.A. 26:4–15.

Case Notes

Hospital must take reasonable steps to insure confidentiality of HIV test results and diagnosis of AIDS when physicians are treated at their own hospitals. Estate of Behringer v. Medical Center at Princeton, 249 N.J.Super. 597, 592 A.2d 1251 (L.1991).

8:57–1.4 Reporting of diseases in an outpatient-based setting

(a) In addition to the reporting requirements of N.J.A.C. 8:57–1.3, any single case, either confirmed or presumed, of the following diseases diagnosed in an outpatient-based setting shall be reported by a health care provider to the local health department:

1. An enteric disease, either in a child who attends a day care center or in a foodhandler;

2. Hemorrhagic colitis;

3. Kawasaki disease (mucocutaneous lymph node syndrome);

4. Lyme disease;

5. Measles;

6. Mumps;

7. Pertussis;

8. Rabies, animal bites treated for rabies;

9. Rubella;

10. Syphilis, primary;

11. Tuberculosis; and

12. Hepatitis C.

(b) A health care provider attending any person who is ill or infected with any disease listed in (a) above shall, within 24 hours of diagnosis, make a report as set forth in (c) below to the health officer of the jurisdiction wherein the diagnosis is made. If the health officer is unavailable, the report shall be made to the Department by telephone (609–588–7500, during business hours; 609–392–2020, after business hours, on weekends and holidays) or by fax (609–588–7431). In cases of venereal diseases and tuberculosis, the reports shall be submitted directly to the Department.

(c) The report shall include the name, municipality and telephone number of the reporting health care provider; the name of the disease; the name, age, date of birth, gender, home address and telephone number of the person ill or infected with such disease; the date of onset of illness; and such other information as may be requested by the Department.

(d) A health care provider may delegate this reporting activity to a staff member, but this delegation does not relieve the health care provider of the ultimate reporting responsibility.

(e) A health care provider who fails to report pursuant to the requirements of this section may receive written notification of this failure and a warning. A health care provider who, despite warning, continues to fail to comply with the reporting requirements, shall be subject to a fine pursuant to the provisions of N.J.S.A. 26:4–129. A health care provider whose failure to report is determined by the Department to have significantly hindered public health control measures, shall be subject to other actions, including, but not limited to, notification of the violation to the State Board of Medical Examiners or State Board of Nursing, as the case may be, and/or appropriate hospital medical directors or administrators.

(f) A health care provider who participates in the Department's Pediatric Surveillance System shall submit data as outlined by the Pediatric Surveillance System. Reports made, maintained, or kept on file pursuant to this section shall not be disclosed with any identifying information.

Amended by R.1990 d.243, effective June 4, 1990.
See: 21 N.J.R. 3897(a), 22 N.J.R. 1766(a).
Text of 1.4, reporting of diseases occurring in institutions, recodified to 1.5, text on reporting of diseases by physicians recodified from 1.3 with reporting requirements changed and (c), (e) and (f) added.
Amended by R.1999 d.305, effective September 7, 1999.
See: 31 N.J.R. 987(b), 31 N.J.R. 2617(a).
Inserted (a)12.

8:57–1.5 Reporting of diseases from hospitals

(a) In addition to the reporting requirements of N.J.A.C. 8:57–1.3, any single case, either confirmed or presumptive, of the following diseases, diagnosed in or admitted to, a hospital shall be reported by the chief executive officer or other person having control or supervision over the hospital to the health officer having jurisdiction over the locality in which the hospital is located:

1. Anthrax;

2. Arboviral diseases;

3. Creutzfeld-Jakob disease;

4. Guillain-Barre syndrome;

5. Hemolytic uremic syndrome;

6. Kawasaki disease (mucocutaneous lymph node syndrome);

7. Legionnaires' disease, nosocomial;

8. Rabies, animal bites treated for rabies;

9. Rheumatic fever, acute;

10. Rubella, congenital;

11. Tetanus;

12. Toxic shock syndrome, streptococcal;

13. Trichinosis;

14. Tuberculosis;

15. Yellow fever; and

16. Hepatitis C.

(b) The chief executive officer or any other person having control or supervision over a hospital with a person who is ill or infected with any of the diseases listed in (a) above shall, within 24 hours of diagnosis, make a written report as set forth in (c), below, to the health officer of the jurisdiction in which the hospital is located. If the health officer is unavailable, the report shall be made to the Department by telephone (609–588–7500, during business hours; 609–392–2020, after business hours, on weekends and holidays) or by fax (609–588–7431). In cases of tuberculosis, the report shall be submitted directly to the Department.

(c) The report shall include the name, municipality, and telephone number of the hospital; the name of the disease; the name, age, date of birth, gender, home address and telephone number of the person who is ill or infected with such disease; the date of onset of illness; and such other information as may be requested by the Department.

(d) A chief executive officer or other person having control or supervision over the hospital may delegate these reporting activities to a staff member, but this delegation does not relieve a chief executive officer or other person having control over the hospital of the ultimate reporting responsibility.

(e) A chief executive officer or other person having control or supervision over a hospital who fails to report pursuant to the provisions of this section may receive written notification of this failure and a warning. Responsible parties who, despite warning, continue to fail to comply with these reporting requirements, shall be subject to a fine, pursuant to the provisions of N.J.S.A. 26:4–129. A chief executive officer or other person having control or supervision over a hospital whose failure to report is determined by the Department to have significantly hindered public health control measures shall be subject to other actions, including, but not limited to, notification of the violation to the Department's Division of Health Facilities Evaluation and any other licensing review organizations.

(f) Notwithstanding the provisions of this rule, a chief executive officer or any other person having control or supervision over a hospital in which an outbreak or suspected outbreak occurs shall make a report as set forth in (c) above to the health officer of the jurisdiction in which the hospital is located. If the health officer is unavailable, the report shall be made to the Department by telephone (609–588–7500, during business hours; 609–392–2020, after business hours, on weekends and holidays) or by fax (609–588–7431).

(g) A chief executive officer or any other person having control or supervision over a hospital shall, within 31 calendar days of the end of each month, submit data regarding specific microorganisms occurring during that month within the hospital to the Department, utilizing the Epidemiology Surveillance Form. Reports made, maintained, or kept on file pursuant to this section shall not be public records.

(h) Effective July 1, 1995, pediatric intensive care units shall, on a weekly basis, report cases of organ failure of presumed communicable or undetermined etiology to the Department. The report may be made to the Department by telephone (609–588–7500, during business hours; 609–392–2020, after business hours, on weekends and holidays) or by fax (609–588–7431). Reports made, maintained, or kept on file pursuant to this subsection shall not be disclosed with any identifying information.

(i) Effective July 1, 1996, medical intensive care units shall, on a weekly basis, report cases of organ failure of presumed communicable or undetermined etiology to the Department. The reports may be made to the Department by telephone (609–588–7500, during business hours; 609–392–2020, after business hours, on weekends and holidays) or by fax (609–588–7431). Reports made, maintained, or kept on file pursuant to this subsection shall not be disclosed with any identifying information.

Amended by R.1990 d.243, effective June 4, 1990.
See: 21 N.J.R. 3897(a), 22 N.J.R. 1766(a).
Text of 1.5, reporting of diseases occurring in schools, recodified to 1.6, text on reporting of diseases occurring in institutions recodified from 1.4 with the addition of homeless shelter, STD and tuberculosis requirements; and new text at (d) through (g). Provisions of (e) operative January 1, 1991.
Amended by R.1999 d.305, effective September 7, 1999.
See: 31 N.J.R. 987(b), 31 N.J.R. 2617(a).
Inserted (a)16.

8:57–1.6 Reporting of diseases from laboratories

(a) In addition to the reporting requirements of N.J.A.C. 8:57–1.3, any positive culture, test, or assay result specific

for one of the following organisms shall be reported by a laboratory director to the health officer:

1. Acid fast bacilli;

2. Antibiotic-resistant organisms (hospital-based laboratories only);

3. Arboviruses;

4. *Babesia spp.;*

5. *Bacillus anthracis;*

6. *Bordetella pertussis;*

7. *Borrelia burgdorferi;*

8. *Brucella spp.;*

9. *Campylobacter jejuni;*

10. *Chlamydia pneumoniae;*

11. *Chlamydia psittaci;*

12. *Chlamydia trachomatis;*

13. *Clostridium botulinum;*

14. *Clostridium tetani;*

15. *Corynebacterium diphtheriae;*

16. *Cryptosporidium spp.;*

17. Ebola virus;

18. *Entamoeba histolytica;*

19. *Ehrlichia canis;*

20. *Escherichia coli 0157: H7;*

21. Foodborne intoxications, including, but not limited to, ciguatera, paralytic shellfish poisoning, scombroid, or mushroom poisoning;

22. *Francisella tularensis;*

23. *Giardia lamblia;*

24. Hanta virus;

25. *Haemophilus ducreyi;*

26. *Haemophilus influenzae isolated from cerebrospinal fluid, blood, needle aspirate, or sputum;*

27. Hepatitis A;

28. Hepatitis B;

29. Hepatitis C;

30. Human papillomavirus;

31. Lassa virus;

32. *Legionella pneumophila;*

33. *Leptospira interrogans;*

34. *Listeria monocytogenes;*

35. Marburg virus;

36. Mumps virus;

37. *Mycobacterium, atypical;*

38. *Mycobacterium leprae;*

39. *Mycobacterium tuberculosis;*

40. *Neisseria gonorrhoeae;*

41. *Neisseria meningitidis* isolated from cerebrospinal fluid, blood, needle aspirate, or any other normally sterile site;

42. Plasmodium spp.;

43. Polio virus;

44. Rabies virus;

45. *Rickettsia spp.* including *Coxiella burnetii* and *Rickettsia rickettsii*;

46. Rubella virus;

47. Rubeola virus;

48. *Salmonella spp.;*

49. *Shigella spp.;*

50. *Streptococcus pyogenes*, Group A, isolated from cerebrospinal fluid or blood;

51. *Streptococcus agalactiae*, Group B, perinatal isolated from cerebrospinal fluid or blood;

52. *Treponema pallidum* (syphilis);

53. *Trichinella spiralis;*

54. *Vibrio spp.;*

55. *Yersinia enterocolitica;*

56. *Yersinia pestis; and*

57. Antibiotic sensitivity for *M. tuberculosis.*

(b) A laboratory director shall report positive cultures or positive laboratory test results for the microorganisms listed in (a) above within five business days after obtaining a positive result. The reports shall be submitted in writing to the health officer having jurisdiction over the locality in which the health care provider requesting the laboratory examination is located.

1. Specific testing procedures for the organisms in (a) above shall be made available periodically from the Department.

2. In cases of venereal diseases, tuberculosis, and *Chlamydia trachomatis*, the reports shall be submitted directly to the Department, no later than 72 hours after the close of business on the day on which the positive cultures or positive test results were obtained.

(c) The report shall contain, at a minimum, the reporting laboratory's name, address, and telephone number; the name, age, sex, and address of the person tested; the test performed; the date of testing; the test results; and the health care provider's name and address.

(d) A laboratory director may delegate reporting and specimen submission activities, as delineated in (g) below, to a staff member, but this delegation does not relieve a laboratory director of the ultimate reporting responsibility.

(e) A laboratory director who fails to fulfill the reporting requirements and the specimen submission requirements of this section may receive written notification of this failure and a warning to comply. A laboratory director who, despite warning, continues to fail to comply with these reporting requirements, shall be subject to a fine pursuant to the provisions of N.J.S.A. 26:4–129. A laboratory director whose failure to report is determined by the Department to have significantly hindered public health control measures shall be subject to other actions, including, but not limited to, reporting such failure to the Department's Clinical Laboratory Improvement Services.

(f) Notwithstanding the provisions of this section, laboratory results indicative or suggestive of the existence of an outbreak of disease, or of any single case of a disease listed in N.J.A.C. 8:57–1.3(a), shall be immediately reported by telephone to the health officer in whose jurisdiction the case is located. A follow-up written report shall be submitted within five business days after the initial report. If the health officer is unavailable, the report shall be made to the Department by telephone (609–588–7500, during business hours; 609–392–2020, after business hours, on weekends and holidays) or by fax (609–588–7431).

(g) A laboratory director shall submit, to the State Department of Health, Division of Public Health and Environmental Laboratories, John Fitch Plaza, Market and Warren Streets, Trenton, NJ 08625–0361, for further testing, all microbiologic cultures obtained from human or food specimens of the following organisms:

1. *Escherichia coli 0157: H7*;

2. *Haemophilus influenzae* isolated from cerebrospinal fluid or blood;

3. *Legionella pneumophila;*

4. *Neisseria meningitidis;*

5. *Salmonella spp.;*

6. *Shigella spp.;*

7. *Streptococcus pyogenes* isolated from cerebrospinal fluid or blood;

8. Penicillin-resistant *Streptococcus pneumoniae* isolated from cerebrospinal fluid or blood; and

9. Vancomycin-resistant *Enterococcus spp.* isolated from cerebrospinal fluid or blood.

Amended by R.1990 d.243, effective June 4, 1990.
See: 21 N.J.R. 3897(a), 22 N.J.R. 1766(a).
Text on reporting of diseases by health officers recodified to 1.8; text on reporting of diseases occurring in schools recodified from 1.5 with notification requirements changed at (a) and new (c) and (d) added.
Administrative Correction in (a): delete "in writing".
See: 22 N.J.R. 2709(a).

8:57–1.7 Reporting of disease outbreaks occurring in institutions and schools

(a) A chief executive officer, superintendent, or other person having control or supervision over any institution such as a sanitarium, nursing home, shelter for the homeless, penal institution, child care center, preschool, school, or college in which an outbreak or suspected outbreak occurs shall immediately report this event by telephone to the health officer having jurisdiction over the locality in which the institution or school is located.

1. If the outbreak occurs in a State institution, the outbreak shall be immediately reported to the Department by telephone (609–588–7500, during business hours; 609–392–2020, after business hours, on weekends and holidays) or by fax (609–588–7431).

(b) The reports shall include the name, municipality and telephone number of the institution or school; the name of the disease or suspected disease; the number ill; dates of onset; symptomology; pertinent medical history and available diagnostic confirmation; and such other information as may be requested by the health officer or the Department.

(c) A chief executive officer, superintendent, or other person having control or supervision over the institution may delegate these reporting activities to a staff member, but this delegation does not relieve the superintendent of the ultimate responsibility.

(d) A chief executive officer, superintendent, or other person having control or supervision over an institution in which an outbreak or suspected outbreak occurs who fails to report pursuant to the requirements of this section may receive written notification of this failure and a warning to comply. A responsible party who, despite warning, continues to fail to comply with these reporting requirements, shall be subject to a fine pursuant to the provisions of N.J.S.A. 26:4–129. A responsible party whose failure to report is determined by the Department to have significantly hindered public health control measures shall be subject to other actions, including, but not limited to, notification to the Department's Division of Health Facilities Evaluation, the Department of Human Services, or the Department of Education, as the case may be, and other licensing review organizations as appropriate.

New Rule, R.1990 d.243, effective June 4, 1990, operative September 1, 1990 (provisions of (a), (c), (d), (f) and (g) only).
See: 21 N.J.R. 3897(a), 22 N.J.R. 1766(a).

8:57–1.8 Reporting of diseases by health officers

(a) A health officer who is notified of any disease outbreak, or of any single case of a disease listed in N.J.A.C. 8:57–1.3(a), shall immediately notify the Department by telephone (609–588–7500, during business hours; 609–392–2020, after business hours, on weekends and holidays) or by fax (609–588–7431).

(b) A health officer who is notified of the existence of diseases pursuant to the provisions of N.J.A.C. 8:57–1.4, 1.5, 1.6, and 1.7 shall, within 24 hours of receipt of the report, forward a copy thereof to the Department. If the initial report is incomplete, a health officer shall seek complete information and shall provide all available information to the Department within five working days of receiving the initial report.

(c) A health officer who is notified of any outbreak of disease, or of any single case of a disease listed in N.J.A.C. 8:57–1.3(a), which is not within that health officer's jurisdiction shall immediately notify the health officer where the disease was believed to have been contracted and the health officer of the local health agency wherein the home address of the ill or affected person is located, as the case may be. If either of the said health agencies are not located in New Jersey, the health officer shall forward this information to the Department by telephone (609–588–7500, during business hours; 609–392–2020, after business hours, on weekends, and holidays) or by fax (609–588–7431).

(d) A health officer may delegate reporting activities to a staff member, but this delegation shall not relieve the health officer of the ultimate reporting responsibility.

(e) A health officer who fails to report pursuant to the provisions of this section shall receive written notification of this failure and a warning. A health officer who, despite warning, fails to comply with these reporting requirements, shall be subject to a fine pursuant to the provisions of N.J.S.A. 26:4–129. A health officer whose failure to report is determined by the Department to have significantly hindered public health control measures shall be subject to

other actions, including notification to the Department's Public Health Licensing and Examination Board and the Public Health Council.

Amended by R.1990 d.243, effective June 4, 1990.
See: 21 N.J.R. 3897(a), 22 N.J.R. 1766(a).
Text on isolation and restriction for communicable diseases recodified to 1.10; text on reporting of diseases by health officers recodified from 1.6 with reporting requirements added at (a) and new (d) and (e) added.

8:57–1.9 Health officer investigations

(a) A health officer shall, upon receiving a report of an outbreak or suspected outbreak of any communicable disease, or of a case or suspected case of any communicable disease, investigate the facts contained in the report. A health officer shall follow such direction regarding the investigation as may be given by the Department.

(b) The health officer performing investigation set forth in (a) above shall, at a minimum:

1. Determine whether a single case or an outbreak of a reportable disease exists;

2. Ascertain the source and spread of the infection; and

3. Determine and implement appropriate control measures.

(c) The health officer shall immediately relay all available information pertaining to the investigation to the Department by telephone (609–588–7500, during business hours; 609–392–2020, after business hours, on weekends, and holidays) or by fax (609–588–7431).

(d) The Department may require more than one health officer to participate in the investigation. The health officers may include those having jurisdiction over:

1. The location of suspected transmission of disease;

2. Areas of residence or occupation of person(s) believed to be ill or infected;

3. Sites of institutions where such persons may be located or receive care; and

4. Other jurisdictions which are determined to be appropriate and necessary by the Department.

8:57–1.10 Isolation and restriction for communicable disease

(a) A health officer or the Department, upon receiving a report of a communicable disease, shall, by written order, establish such isolation or other restrictive measures required by statute or rule to prevent or control disease. If, in the judgment of the health officer or the Department, it is necessary to provide adequate isolation, a health officer or the Department shall promptly remove, or cause to be removed, a person who is ill with a communicable disease to a hospital. Such order shall remain in force until terminated by the health officer or the Department.

(b) A health officer or the Department may restrict access of the individuals permitted to come in contact with or visit a person who is hospitalized or isolated under authority of this section.

(c) The Department or health officer, if authorized by local ordinance or by the Department, may, by written order, restrict any person who has been exposed to a communicable disease, under conditions he or she may specify; providing such period of restriction shall not exceed the period of incubation of the disease.

(d) A person who is responsible for the care, custody, or control of a person who is ill or infected with a communicable disease shall take all measures necessary to prevent transmission of the disease to other persons.

Amended by R.1990 d.243, effective June 4, 1990.
See: 21 N.J.R. 3897(a), 22 N.J.R. 1766(a).
Text on medical examination and submission of specimens recodified to 1.11; text on health officer investigations recodified to 1.9 with further specification of investigation requirements.

8:57–1.11 Medical examination and specimen submission

(a) The Department or a health officer may order a person who is suspected of being ill or infected with a reportable or communicable disease, or who has been exposed to a reportable or communicable disease, to submit to physical examination, X-ray studies, laboratory studies, and such other diagnostic procedures as deemed necessary to determine whether or not such person is communicable to others or is a carrier of disease.

(b) Any person who is ordered to submit to examination and/or to submit specimens under (a) above shall comply with the order.

(c) Specimens obtained under the authority of this chapter and under provisions of this rule shall be submitted to a laboratory which is approved by the Department for examination of such specimens.

Amended by R.1990 d.243, effective June 4, 1990.
See: 21 N.J.R. 3897(a), 22 N.J.R. 1766(a).
Text on ill or infected foodhandlers recodified to 1.12; on medical examination and submission of specimens recodified from 1.9.

8:57–1.12 Foodhandlers ill or infected with communicable diseases

(a) A person who is ill or infected with a communicable disease which may be transmitted through food may, based on the type of organism, job function of the person, and the virulence of the disease, be prohibited by a health officer or the Department from working in any occupation that manufactures, processes, stores, prepares, or serves food for public consumption. A person who resides in, boards at, lodges in, or visits a household where that person may come in contact with any person who is ill or infected with a communicable disease which may be transmitted through food may be prohibited by the health officer or the Department from working in any occupation that manufactures, processes, stores, prepares, or serves food for public consumption.

(b) A person who is employed in any establishment where food is manufactured, processed, stored, prepared, or served for public consumption may be required by a health officer or the Department, if a communicable disease is suspected, to submit to a physical examination and/or submit specimens of blood, bodily discharges, or other specimens for the purpose of ascertaining whether or not they are ill or infected with a communicable disease.

(c) A health officer or the Department may prohibit the sale or distribution of food which:

1. Has been prepared by a person who is ill or infected with a communicable disease which may be transmitted through food; or

2. Is considered to be a possible vehicle for spread of disease.

Amended by R.1990 d.243, effective June 4, 1990.
See: 21 N.J.R. 3897(a), 22 N.J.R. 1766(a).
Text on ill or infected foodhandlers recodified from 1.11.

SUBCHAPTER 2. REPORTING OF ACQUIRED IMMUNODEFICIENCY SYNDROME AND INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS

8:57–2.1 Applicability; definition of AIDS, HIV infection and CD4 count

(a) The provisions of this subchapter are applicable to cases of Acquired Immunodeficiency Syndrome (AIDS) and infection with human immunodeficiency virus (HIV). The provisions of N.J.A.C. 8:57–1 shall not apply to any case of AIDS or infection with HIV.

(b) Laboratory results indicative of infection with HIV shall mean laboratory results showing the presence of HIV or components of HIV, or of laboratory results showing the presence of antibodies to HIV. The State Commissioner of Health shall determine the laboratory test results which indicate infection with HIV for the purpose of these rules.

(c) Acquired immunodeficiency syndrome (AIDS) means a condition affecting a person who has a reliably diagnosed disease that meets the criteria for AIDS specified by the Centers for Disease Control of the United States Public Health Services.

(d) A CD4 count means a count of lymphocytes containing the CD4 epitope as determined by the results of lymphocyte phenotyping. An absolute CD4 count means the number of lymphocytes containing the CD4 epitope per cubic millimeter. A relative CD4 count means the number of such cells expressed as a percentage of total lymphocytes.

Amended by R.1992 d.215, effective May 18, 1992.
See: 23 N.J.R. 3735(a), 24 N.J.R. 1891(b).
AIDS definition based on CD4 count designated by CDC.

8:57–2.2 Reporting HIV infection

(a) Every physician attending a person found to be infected with HIV shall, within 24 hours of receipt of a laboratory report indicating such a condition, report in writing such condition directly to the State Department of Health on forms supplied by the State Department of Health. The report shall include the name and address of the reporting physician, the name, address, gender, race and birth date of the person found to be infected with HIV, the date the specimen tested for HIV was obtained, and such other information as may be required by the State Department of Health. A physician shall not report a person infected with HIV if the physician is aware that the person having control or supervision of an institution named in (b) below is reporting that person as being infected with HIV, or if the physician is aware that the person has previously been reported to the State Department of Health as being infected with HIV.

(b) The person having control or supervision over any institution, such as a hospital, sanitarium, nursing home, penal institution, clinic, blood bank, or facility for HIV counseling and testing in which any person is determined to be infected with HIV shall, within 24 hours of receipt of a laboratory report indicating such a condition, report in writing such condition directly to the State Department of Health on forms supplied by the State Department of Health. The report shall state the name, address, gender, race, and birth date of the person found to be infected with HIV, the date the specimen tested for HIV was obtained, the name of the attending physician, the name and address of the institution, and such other information as may be required by the State Department of Health. The person having control or supervision of the institution shall not report a person infected with HIV if it is known that a physician is reporting the person or that the person has previously been reported to the State Department of Health as being infected with HIV. The person having control or supervision of the institution may delegate this reporting activity to a member of the staff, but this delegation does not relieve the controlling or supervising person of the ultimate report responsibility.

(c) Every clinical laboratory shall, within five working days of completion of a laboratory test which has results indicative of infection with HIV, report in writing such results to the State Department of Health. The report shall include the name and address of the clinical laboratory, the name and address of the submitter of the laboratory specimen, any identifying information the laboratory may have on the person from whom the laboratory specimen was obtained, including the unique code if a code is the only information identifying the person from whom the laboratory specimen was obtained, and other epidemiological information as may be required by the State Department of Health on a general or a case-by-case basis. Only specimens sent to the laboratory from physicians' offices in New Jersey or from institutions in New Jersey should be reported.

Amended by R.1991 d.516, effective October 21, 1991.
See: 23 N.J.R. 2089(a), 23 N.J.R. 3138(b).
Reporting of HIV results with identifiers required.
Amended by R.1992 d.215, effective May 18, 1992.
See: 23 N.J.R. 3735(a), 24 N.J.R. 1891(b).
Clinical labs to report results indicative of HIV within five working days.

8:57–2.3 Reporting AIDS

(a) Every physician attending any person ill with AIDS shall, within 24 hours of the time AIDS is diagnosed, report in writing such condition directly to the State Department of Health on forms supplied by the State Department of Health. The report shall include the name and address of the reporting physician, the name, address, gender, race, and birth date of the person ill with AIDS, the date of onset of the illness meeting the criteria for the diagnosis of AIDS, and such other information as may be required by the State Department of Health. Such report should be made whether or not the patient previously had been reported as having HIV infection. The report of AIDS will be deemed to also be a report of HIV infection.

(b) The person having control or supervision over any institution, such as a hospital, sanitarium, nursing home, penal institution, or clinic, in which a person is ill with AIDS shall, within 24 hours of the time AIDS is diagnosed, report such condition in writing directly to the State Department of Health on forms provided by the State Department of Health. The report shall state the name, address, gender, race and birth date of the person ill with AIDS, the date of onset of the illness meeting the criteria for the diagnosis of AIDS, the name of the attending physician, the name and address of the institution, and such other information as may be required by the State Department of Health. Such report should be made whether or not the patient previously had been reported as having HIV infection. The report of AIDS will be deemed to also be a report of HIV infection. The person having control or supervision of the institution may delegate this reporting responsibility to a member of the staff, but this delegation does not relieve the controlling or supervising person of the ultimate reporting responsibility.

(c) Every clinical laboratory shall, within five working days of completion of a CD4 count which has absolute or relative results below a level specified by the Centers for Disease Control as criteria for defining AIDS, report in writing such results to the State Department of Health. The report shall include the name and address of the clinical laboratory, the name and address of the submitter of the laboratory specimen, identifying information the laboratory may have on the person from whom the laboratory specimen was obtained, including the unique code if a code is the only information identifying the person from whom the laboratory specimen was obtained, and other epidemiological information as may be required by the State Department of Health on a general or a case-by-case basis. Only specimens sent to the laboratory from physicians' offices in New Jersey or from institutions in New Jersey should be reported.

Amended by R.1992 d.215, effective May 18, 1992.
See: 23 N.J.R. 3735(a), 24 N.J.R. 1891(b).
Clinical labs to report results below a CDC-specified CD4 level within five working days.

8:57–2.4 Testing procedures

No physician or institution may direct a person be tested for HIV, a component of HIV, or antibodies to HIV, unless the name and address of the person whose specimen is being tested is known and recorded by the physician or institution, except that the State Commissioner of Health may designate facilities which are permitted to test for antibodies to HIV without obtaining the name and address of the person being tested. The name and address of a person requesting testing without giving his or her name and address at such a designated facility are not required to be reported to the State Department of Health.

Amended by R.1991 d.516, effective October 21, 1991.
See: 23 N.J.R. 2089(a), 23 N.J.R. 3138(b).
Exception to reporting of HIV results with identifiers provided for State-designated testing facilities.

8:57–2.5 Exceptions to communicable disease classification of AIDS and HIV

(a) AIDS or HIV infection shall not be considered a communicable disease for purposes of admission to, attendance in, or transportation in any of the following:

1. Nursing homes and other health care facilities;
2. Rooming and boarding homes, and shelters for the homeless;
3. Ambulances and other public conveyances; and
4. Educational facilities.

8:57–2.6 Access to information

As provided by N.J.S.A. 26:4–2 and 26:5C–5 through 14, the information reported to the Department shall not be subject to public inspection, but shall be subject to access only by the State Department of Health for public health purposes.

Amended by R.1991 d.516, effective October 21, 1991.
See: 23 N.J.R. 2089(a), 23 N.J.R. 3138(b).
Stylistic changes.

8:57–2.7 Failure to comply with reporting requirements

(a) Physicians failing to fulfill the reporting requirements of this subchapter may receive written notification of this failure. Physicians failing to meet these reporting requirements, despite warning, shall be subject to a fine, as allowed by N.J.S.A. 26:4–129. In addition, those whose failure to report is determined by the State Department of Health to have significantly hindered public health control measures shall be subject to other actions, including notification of the Board of Medical Examiners of the State Department of Law and Public Safety, and appropriate hospital medical directors or administrators.

(b) The person having control or supervision over any institution, who fails to fulfill the aforementioned reporting obligations, may receive written notification of this failure. Superintendents failing to meet these reporting requirements, despite warning, shall be subject to a fine, as allowed by N.J.S.A. 26:4–129. In addition, those whose failure to report is determined by the State Department of Health to have significantly hindered public health control measures, shall be subject to other actions, including notification of the State Department of Health, Division of Health Facilities Evaluation, other appropriate licensing review organizations, and other appropriate agencies.

(c) Laboratory supervisors failing to fulfill the aforementioned reporting obligations may receive written notification of this failure. Supervisors failing to meet these requirements, despite warning, shall be subject to fines as allowed by N.J.S.A. 26:4–129. In addition, those whose failure to report is determined by the State Department of Health to have significantly hindered public health control measures, shall be subject to other actions, including notification to the State Clinical Laboratory Improvement Services.

Amended by R.1991 d.516, effective October 21, 1991.
See: 23 N.J.R. 2089(a), 23 N.J.R. 3138(b).
Requirement to submit specimens corrected.

SUBCHAPTER 3. REPORTABLE OCCUPATIONAL AND ENVIRONMENTAL DISEASES AND POISONS

8:57–3.1 Reporting of occupational and environmental diseases and poisonings by hospitals

(a) The chief administrator or other persons having control or supervision over any hospital in which any person has been diagnosed with any of the diseases or poisonings listed in (b) and (c) below shall, within 30 days after discharge, report such disease or poisoning to the State Department of Health and to the health officer having jurisdiction over the territory in which such hospital is located. Health officers who receive reports of diseases or poisonings required under (b) and (c) below shall send a copy thereof to the health officer having jurisdiction over the territory in which such person resides within seven days of receipt of the report. The disease or poisoning shall be considered diagnosed if it is listed as a primary or secondary diagnosis on the discharge summary.

(b) The following diseases are declared to be reportable to the parties specified in (a) above for purposes of this section. All diseases listed herein coded according to the 9th ICD revision are to be reported in the manner prescribed by (d) below:

1. Extrinsic allergic alveolites, ICD code 495, 495.0, 495.1, 495.2, 495.3, 495.4, 495.5, 495.6, 495.7, 495.8, 495.9;

2. Coal workers pneumoconiosis, ICD code 500;

3. Asbestosis, ICD code 501;

4. Silicosis, ICD code 502;

5. Pneumoconiosis, other dust inorganic, ICD code 503;

6. Pneumonopathy due to organic dust, ICD code 504;

7. Pneumoconiosis, unspecified, ICD code 505;

8. Bronchitis, Pneumonitis, inflammation both acute and chronic and acute pulmonary edema due to fumes and vapors, ICD code 506.0, 506.1, 506.2, 506.3, 506.4, and 506.9; and

9. Respiratory conditions due to unspecified external agents, ICD codes 508.8 and 508.9.

(c) Poisoning due to the following and not the result of a suicidal attempt shall also be reported to the parties specified in (a) above in the manner prescribed by (d) below.

petroleum products	ICD 981
benzene	ICD 982.0
carbon tetrachloride	ICD 982.1
carbon disulfide	ICD 982.2
chlorinated hydrocarbons	ICD 982.3
nitroglycol	ICD 982.4
non-petroleum-based solvents	ICD 982.8
corrosive aromatics	ICD 983.0
acids	ICD 983.1
alkalies	ICD 983.2
caustic unspecified	ICD 983.9
inorganic lead	ICD 984.0
organic lead	ICD 984.1
mercury	ICD 985.0
arsenic	ICD 985.1
manganese	ICD 985.2
beryllium	ICD 985.3
antimony	ICD 985.4
cadmium	ICD 985.5
chromium	ICD 985.6
other specified metals	ICD 985.8
unspecified metals	ICD 985.9
petroleum gases	ICD 987.0
other hydrocarbon gas	ICD 987.1
nitrogen oxides	ICD 987.2
sulfur dioxide	ICD 987.3
freon	ICD 987.4
chlorine	ICD 987.6
hydrogen cyanide	ICD 987.7
other gases	ICD 987.8
unspecified gas, fume, vapor	ICD 987.9
hydrogen cyanide	ICD 989.0
pesticides	ICD 989.2, 989.3 and 989.4

(d) The report required by (a) above shall state on forms supplied by the State Department of Health the name and current ICD code of the disease or poisoning and shall indicate whether this condition was a primary or secondary diagnosis. The following information on the person diagnosed with such disease or poisoning shall also be furnished:

name, home address, medical record number, year of birth, sex, race, name and address of employer. The report shall also include the name of the attending physician, the reporting hospital, the date of discharge and such other information as may be required by the State Department of Health.

8:57–3.2 Reporting of occupational and environmental diseases and injuries by physicians

(a) The physician attending any person who is ill or diagnosed with any of the diseases or injuries listed in (b) below shall, within 30 days after such condition has been diagnosed or treated, report such condition to the State Department of Health.

(b) The following diseases and injuries are declared to be reportable to the State Department of Health for purposes of this section. All conditions listed herein are to be reported in the manner prescribed by (c) below:

1. Asbestosis;
2. Silicosis;
3. Pneumoconiosis, other and unspecified;
4. Occupational asthma;
5. Extrinsic Allergic Alveolitis;
6. Lead toxicity, adult (defined as blood lead ≥ 25 micrograms per deciliter; urine lead ≥ 80 micrograms per liter);
7. Arsenic toxicity, adult (defined as blood arsenic ≥ .07 micrograms per milliliter; urine arsenic ≥ 100 micrograms per liter;
8. Mercury toxicity, adult (defined as blood mercury ≥ 2.8 micrograms per deciliter; urine mercury ≥ 20 micrograms per liter);
9. Cadmium toxicity, adult (defined as blood cadmium ≥ five micrograms per liter of whole blood; urine cadmium ≥ three micrograms per gram creatinine);
10. Pesticide toxicity;
11. Work-related injuries in children (under age 18); and
12. Work-related fatal injuries.

(c) The report required by (a) above shall state the name of the disease or injury and the name of the reporting physician. The following information on the person ill or diagnosed with such condition shall also be furnished: name, year of birth, sex, home address, telephone number, name and address of employer at the time of exposure or injury, and the date of onset of illness or injury. Additional information may be required by the Department after receipt of a specific report.

Amended by R.1993 d.569, effective November 15, 1993.
See: 25 N.J.R. 2186(a), 25 N.J.R. 5164(b).

SUBCHAPTER 4. IMMUNIZATION OF PUPILS IN SCHOOL

8:57–4.1 Applicability

This subchapter shall apply to all children attending any public or private school, child care center, nursery school, preschool or kindergarten in New Jersey.

Amended by R.1990 d.243, effective June 4, 1990 (operative September 1, 1991).
See: 21 N.J.R. 3897(a), 22 N.J.R. 1766(a).
Preschool added.
Amended by R.1995 d.201, effective April 3, 1995.
See: 27 N.J.R. 270(a), 27 N.J.R. 1417(a).

8:57–4.2 Proof of immunization

A principal, director or other person in charge of a school, preschool, or child care facility shall not knowingly admit or retain any child whose parent or guardian has not submitted acceptable evidence of the child's immunization, according to the schedules specified in this subchapter. Exemptions to this requirement are identified at N.J.A.C. 8:57–4.3 and 4.4.

Amended by R.1990 d.243, effective June 4, 1990 (operative September 1, 1991).
See: 21 N.J.R. 3897(a), 22 N.J.R. 1766(a).
Preschool added.
Amended by R.1995 d.201, effective April 3, 1995.
See: 27 N.J.R. 270(a), 27 N.J.R. 1417(a).

8:57–4.3 Medical exemptions

(a) A child shall not be required to have any specific immunization(s) which are medically contraindicated.

(b) A written statement submitted to the school, preschool, or child care center from a physician licensed to practice medicine or osteopathy in any jurisdiction of the United States indicating that an immunization is medically contraindicated for a specific period of time, and the reason(s) for the medical contraindication, based upon valid medical reasons as enumerated by the Advisory Committee on Immunization Practices (ACIP) of the United States Public Health Service or the American Academy of Pediatrics (AAP) guidelines, will exempt a pupil from the specific immunization requirement for the stated period of time.

1. The guidelines identified in (b) above are available as follows:

i. Advisory Committee on Immunization Practices, U.S. Public Health Service, Centers for Disease Control and Prevention, Atlanta, GA 30333; and

ii. American Academy of Pediatrics, Committee on Infectious Diseases, PO Box 927, Elk Grove, IL 60009–0927.

(c) The physician's statement shall be retained as part of the child's immunization record and shall be reviewed annually by the school, preschool, or child care facility. When the child's medical condition permits immunization, this exemption shall thereupon terminate and the child shall be required to obtain the immunization(s) from which he or she has been exempted.

(d) Those children with medical exemptions to receiving specific immunizations may be excluded from the school, preschool, or child care facility during a vaccine-preventable disease outbreak or threatened outbreak as determined by the State Commissioner of Health or his or her designee.

(e) As provided by N.J.S.A. 26:4–6, "Any body having control of a school may, on account of the prevalence of any communicable disease, or to prevent the spread of communicable diseases, prohibit the attendance of any teacher or pupil of any school under their control and specify the time during which the teacher or scholar shall remain away from school." The State Department of Health shall provide guidance to the school of the appropriateness of any such prohibition. All schools are required to comply with the provisions of N.J.A.C. 8:61–1.1 regarding attendance at school by pupils or adults infected by Human Immunodeficiency Virus (HIV).

Amended by R.1995 d.201, effective April 3, 1995.
See: 27 N.J.R. 270(a), 27 N.J.R. 1417(a).

8:57–4.4 Religious exemptions

(a) A child shall be exempted from mandatory immunization if the parent or guardian objects thereto in a written statement submitted to the school, preschool, or child care center, signed by the parent or guardian, explaining how the administration of immunizing agents conflicts with the pupil's exercise of bona fide religious tenets or practices. General philosophical or moral objection to immunization shall not be sufficient for an exemption on religious grounds.

(b) This statement will be kept by the school, preschool, or child care center as part of the child's immunization record.

(c) Those children with religious exemptions from receiving immunizing agents may be excluded from the school, preschool, or child care center during a vaccine-preventable disease outbreak or threatened outbreak as determined by the State Commissioner of Health or his or her designee.

(d) As provided by N.J.S.A. 26:4–6, "Any body having control of a school may, on account of the prevalence of any communicable disease, or to prevent the spread of communicable diseases, prohibit the attendance of any teacher or pupil of any school under their control and specify the time during which the teacher or scholar shall remain away from school." The State Department of Health shall provide guidance to the school on the appropriateness of any such prohibition. All schools are required to comply with the provisions of N.J.A.C. 8:61–1.1 regarding attendance at school by pupils or adults infected by Human Immunodeficiency Virus (HIV).

(e) Those children enrolled in school, preschool, or child care centers before September 1, 1991, and who have previously been granted a religious exemption, shall not be required to reapply for a new religious exemption under N.J.A.C. 8:57–4.4(a).

Amended by R.1990 d.243, effective June 4, 1990 (operative September 1, 1991).
See: 21 N.J.R. 3897(a), 22 N.J.R. 1766(a).
Title changed; explanation required in (a); new (d) and (e) added.
Amended by R.1995 d.201, effective April 3, 1995.
See: 27 N.J.R. 270(a), 27 N.J.R. 1417(a).

8:57–4.5 Provisional admission

(a) A child may be admitted to a school, preschool, or child care center on a provisional basis if a physician or health department can document that at least one dose of each required age-appropriate vaccine(s) or antigen(s) has been administered and that the pupil is in the process of receiving the remaining immunization(s).

(b) Provisional admission for children under age five shall be granted in compliance with the specific requirements set forth in N.J.A.C. 8:57–4.10 through 4.15 for a period of time consistent with the current Advisory Committee on Immunization Practices (ACIP) of the United States Public Health Service or the American Academy of Pediatrics (AAP) immunization schedule, but shall not exceed 17 months for completion of all immunization requirements.

(c) Provisional admission for children five years of age or older shall be granted in compliance with the specific requirements set forth in N.J.A.C. 8:57–4.10 through 4.14 for a period of time consistent with the current Advisory Committee on Immunization Practices (ACIP) of the United States Public Health Service or the American Academy of Pediatricians (AAP) immunization schedule, but shall not exceed one year for completion of all immunization requirements.

(d) Provisional status shall only be granted one time to children entering or transferring into schools, preschools, or child care centers in New Jersey. Information on this status shall be sent by the original school, preschool, or child care center to the new school, preschool, or child care center pursuant to N.J.A.C. 8:57–4.7(b).

(e) Those children transferring into a New Jersey school, preschool, or child care center from out-of-State or out-of-country may be allowed a 30–day grace period in order to obtain past immunization documentation before provisional status shall begin.

(f) The school, preschool, or child care center shall ensure that the required vaccine/antigens are being received

on schedule. If at the end of the provisional admission period, the child has not completed the required immunizations, the administrative head of the school, preschool or child care center shall exclude the child from continued school attendance until appropriate documentation has been presented.

(g) Those children in provisional status may be temporarily excluded from the school, preschool, or child care center during a vaccine-preventable disease outbreak or threatened outbreak as determined by the State Commissioner of Health or his or her designee.

As amended, R.1981 d.502, effective January 4, 1982.
See: 13 N.J.R. 738(a), 14 N.J.R. 45(c).
(b): Reference to N.J.A.C. 8:57–4.15 added.
Amended by R.1990 d.243, effective June 4, 1990 (operative September 1, 1991).
See: 21 N.J.R. 3897(a), 22 N.J.R. 1766(a).
Text at (a) revised; text at (b) deleted and new text added at (b) through (g).
Amended by R.1995 d.201, effective April 3, 1995.
See: 27 N.J.R. 270(a), 27 N.J.R. 1417(a).

8:57–4.6 Documents accepted as evidence of immunization

(a) The following documents shall be accepted as evidence of a child's immunization history provided that the type of immunization and the date when each immunization was administered is listed:

1. An official school record from any school, preschool, or child care center indicating compliance with the immunization requirements of this subchapter; or

2. A record from any public health department indicating compliance with the immunization requirements of this subchapter; or

3. A certificate signed by a physician licensed to practice medicine or osteopathy in any jurisdiction of the United States indicating compliance with the immunization requirements of this subchapter.

(b) All immunization records submitted by a parent or guardian in a language other than English shall be accompanied by a translation sufficient to determine compliance with the immunization requirements of this subchapter.

Amended by R.1990 d.243, effective June 4, 1990 (operative September 1, 1991).
See: 21 N.J.R. 3897(a), 22 N.J.R. 1766(a).
Preschool added at (a)1; (a)4 deleted; (b) added.
Amended by R.1995 d.201, effective April 3, 1995.
See: 27 N.J.R. 270(a), 27 N.J.R. 1417(a).

8:57–4.7 Records required

(a) Every school, preschool, or child care center shall maintain an official State of New Jersey School Immunization Record for every pupil. This record shall include the date of each immunization and shall be separated from the child's other medical records for purpose of immunization record audit.

(b) If a child withdraws, is promoted, or transfers to another school, preschool, or child care center, the immunization record, or a certified copy thereof, along with statements pertaining to religious or medical exemptions and laboratory evidence of immunity, shall be sent to the new school by the original school or shall be given to the parent or guardian upon request, within 24 hours of such a request.

(c) When a child graduates from secondary school, this record, or a certified copy thereof, shall be sent to an institution of higher education or may be given to the parent or guardian upon request.

(d) Each child's official New Jersey School Immunization Record, or a certified copy thereof, shall be retained by every secondary school for a minimum of four years after the pupil has left the school. Every elementary school, preschool, or child care center shall retain an immunization record, or a copy thereof, for a minimum of one year after the child has left the school.

(e) Any computer-generated document or list developed by a school, preschool, or child care center shall be considered a supplement to, and not a replacement of, the official New Jersey School Immunization Record.

Amended by R.1990 d.243, effective June 4, 1990 (operative September 1, 1991).
See: 21 N.J.R. 3897(a), 22 N.J.R. 1766(a).
Preschool added; text at (b) deleted; record to go to new school within 24 hours; new (c), (d) and (e) added.
Amended by R.1995 d.201, effective April 3, 1995.
See: 27 N.J.R. 270(a), 27 N.J.R. 1417(a).

8:57–4.8 Reports to be sent to State Department of Health

(a) A report of the immunization status of the pupils in every school, preschool, or child care center shall be sent each year to the State Department of Health by the principal, director, or other person in charge of the school, preschool, or child care center.

(b) The form for the annual immunization status report shall be provided by the State Department of Health.

(c) This report shall be submitted by December 1 of the respective academic year after a review of all appropriate immunization records.

(d) A copy of this report shall be sent to the local board of health in whose jurisdiction the school, preschool, or child care center is located.

(e) Those schools, preschools, and child care centers not submitting the annual report by December 1 will be considered delinquent. A delinquency involving schools, preschools, and child care centers may be referred to the New Jersey State Department of Education or the New Jersey State Department of Human Services, as appropriate based on the length of time delinquent, number of times delinquent, and efforts made toward compliance. The local health department will also be notified of the delinquency.

As amended, R.1978 d.244, effective July 24, 1978.
See: 10 N.J.R. 246(b), 10 N.J.R. 334(a).
Amended by R.1990 d.243, effective June 4, 1990 (operative September 1, 1991).
See: 21 N.J.R. 3897(a), 22 N.J.R. 1766(a).
Preschool added; new (e) added.
Amended by R.1995 d.201, effective April 3, 1995.
See: 27 N.J.R. 270(a), 27 N.J.R. 1417(a).

8:57–4.9 Records available for inspection

Each school, preschool, and child care center shall maintain records of their children's immunization status. Upon 24 hour notice, these records shall be made available for inspection by authorized representatives of the State Department of Health or the local board of health in whose jurisdiction the school or child care center is located.

Amended by R.1990 d.243, effective June 4, 1990 (operative September 1, 1991).
See: 21 N.J.R. 3897(a), 22 N.J.R. 1766(a).
Preschool and 24 hour requirement added.
Amended by R.1995 d.201, effective April 3, 1995.
See: 27 N.J.R. 270(a), 27 N.J.R. 1417(a).

8:57–4.10 Diphtheria and tetanus toxoids and pertussis vaccine

(a) Every child born on or after January 1, 1986 shall have received a minimum of four doses of diphtheria and tetanus toxoids and pertussis vaccine (DTP), or any vaccine combination containing DTP, such as DTP/Hib, one dose of which shall have been given on or after the child's fourth birthday.

(b) Those children enrolled in child care centers who are too young to meet this requirement, shall be in compliance with this section if they are appropriately immunized for their age as recommended by the Advisory Committee on Immunization Practices (ACIP) of the United States Public Health Service.

(c) Pediatric diphtheria-tetanus toxoid (DT) shall be accepted in lieu of DTP or DTaP for children under age seven if a physician's written medical contraindication to further pertussis vaccine has been presented as specified at N.J.A.C. 8:57–4.3.

(d) Diphtheria, tetanus, and acellular pertussis vaccine (DTaP) for children under age seven shall be accepted in lieu of DTP vaccine for the fourth or fifth dose in the DTP series, if given on or after 15 months of age.

(e) Children seven years of age and older who have not completed this requirement shall receive tetanus and diphtheria toxoids (adult Td) instead of DTP. Any appropriately spaced combination of three doses of DTP, DTaP, DT, or Td in a child over age seven shall be acceptable as adequate immunization for this vaccine series.

(f) The requirement to receive a school entry booster dose of DTP after the child's fourth birthday shall not apply to children while enrolled in child care centers.

(g) Those children born on or after January 1, 1986, who have received a total of five or more doses of DTP and DTaP shall have satisfied the DTP requirement.

As amended, R.1981 d.503, effective January 4, 1982.
See: 13 N.J.R. 738(a), 14 N.J.R. 45(c).
"Seventh" birthday was "sixth".
Amended by R.1990 d.243, effective June 4, 1990 (operative September 1, 1991).
See: 21 N.J.R. 3897(a), 22 N.J.R. 1766(a).
DTP schedule updated; new (b), (c) and (d) added.
Amended by R.1995 d.201, effective April 3, 1995.
See: 27 N.J.R. 270(a), 27 N.J.R. 1417(a).

Case Notes

Risk-modified market-share liability not adopted in DPT action. Shackil v. Lederle Laboratories, a div. of American Cyanamid Co., 116 N.J. 155, 561 A.2d 511 (1989).

Adequacy of warning left to jury. Niemiera by Niemiera v. Schneider, 114 N.J. 550, 555 A.2d 1112 (1989).

Learned intermediary doctrine relieved manufacturer of vaccine of duty to warn parents of child who suffered disabling convulsive episode which left him brain damaged. Niemiera by Niemiera v. Schneider, 114 N.J. 550, 555 A.2d 1112 (1989).

8:57–4.11 Poliovirus vaccine

(a) Every child born on or after January 1, 1986 shall have received at least three doses of live, trivalent, oral poliovirus vaccine (OPV), or inactivated poliovirus vaccine (IPV) if medically appropriate, either separately or in combination, one dose of which shall have been given on or after the child's fourth birthday.

(b) Those children enrolled in child care centers who are too young to meet this requirement, shall be considered to be in compliance with this section if they are appropriately immunized for their age as recommended by the Advisory Committee on Immunization Practices (ACIP) of the United States Public Health Service.

(c) Any child 18 years of age or older shall not be required to receive poliovirus vaccine.

(d) For children seven years of age and older, any appropriately spaced combination of three doses of OPV or IPV shall satisfy the poliovirus vaccine requirement.

(e) The requirement to receive a school entry dose of OPV or IPV after the child's fourth birthday shall not apply to children while enrolled in child care centers.

As amended, R.1978 d.244, effective July 24, 1978.
See: 10 N.J.R. 246(b), 10 N.J.R. 334(a).
Amended by R.1990 d.243, effective June 4, 1990 (operative September 1, 1991).
See: 21 N.J.R. 3897(a), 22 N.J.R. 1766(a).
Vaccine requirements updated at (a) and (c); text deleted from (b) and new text added at (b), (d), (e) and (f).
Amended by R.1995 d.201, effective April 3, 1995.
See: 27 N.J.R. 270(a), 27 N.J.R. 1417(a).

8:57–4.12 Measles virus vaccine

(a) Every child born on or after January 1, 1990 shall have received two doses of a live measles-containing vaccine, or any vaccine combination containing live measles vaccine, such as the preferred measles, mumps, rubella (MMR) vaccine, prior to school entrance for the first time into Kindergarten, Grade One, or a comparable age entry level special education program with an unassigned grade. The first dose shall have been administered on or after the child's first birthday, and the second dose shall have been administered no less than one month after the first dose.

(b) Those children younger than 15 months of age who are enrolled in a preschool or child care center, shall be considered to be in compliance with this section until reaching the age of 15 months, which is the medically recommended age for receiving the first measles immunization.

(c) Children born before January 1, 1990 shall have received one dose of live measles vaccine or any measles-containing combination vaccine on or after their first birthday.

(d) Children born on or after January 1, 1990 and enrolling in school (Kindergarten or Grade One) for the first time after September 1, 1995, with no documented doses of measles vaccine, shall receive the second dose of measles or another measles-containing combination vaccine, no sooner than one month and no later than two months after receiving the first dose.

(e) Children who present documented laboratory evidence of measles immunity shall not be required to receive measles vaccine.

(f) Those children enrolled in school, preschool, or child care centers before September 1, 1991 who have a current immunization record with physician diagnosed and documented measles disease shall not be required to receive the first or second dose of measles vaccine.

As amended, R.1981 d.502, effective January 4, 1982 (except (c)).
See: 13 N.J.R. 738(a), 14 N.J.R. 45(c).
(c): "as certified ... immunity" added; (c)1 added.
Amended by R.1990 d.243, effective June 4, 1990 (operative September 1, 1991).
See: 21 N.J.R. 3897(a), 22 N.J.R. 1766(a).
Text deleted rule and new text added.
Amended by R.1995 d.201, effective April 3, 1995.
See: 27 N.J.R. 270(a), 27 N.J.R. 1417(a).

8:57–4.13 Rubella vaccine

(a) Every child shall have received one dose of live rubella virus vaccine, or any vaccine combination containing live rubella virus vaccine, administered on or after the child's first birthday.

(b) Those children younger than 15 months of age who are enrolled in a preschool or child care center, shall be considered to be in compliance with this section until reaching the age of 15 months, which is the medically recommended age for routine rubella immunization.

(c) Rubella virus vaccine shall not be required of children who present documented laboratory evidence of rubella immunity.

As amended, R.1981 d.502, effective January 4, 1982 (except (b)).
See: 13 N.J.R. 738(a), 14 N.J.R. 45(c).
(b): "who present ... immunity" substituted for "after the twelfth birthday"; (b)1 added.
Amended by R.1990 d.243, effective June 4, 1990 (operative September 1, 1991).
See: 21 N.J.R. 3897(a), 22 N.J.R. 1766(a).
Text added at (a); new (b) and old (b) moved to (c) with text added; (b)1 deleted.
Amended by R.1995 d.201, effective April 3, 1995.
See: 27 N.J.R. 270(a), 27 N.J.R. 1417(a).
Administrative Correction.
See: 27 N.J.R. 1801(a).

8:57–4.14 Mumps vaccine

(a) Every child shall have received one dose of live mumps virus vaccine, or any vaccine combination containing live mumps virus vaccine, administered on or after the child's first birthday.

(b) Those children younger than 15 months of age who are enrolled in a preschool or child care center shall be considered to be in compliance with this section until reaching the age of 15 months, which is the medically recommended age for routine mumps immunization.

(c) Children enrolled in school, preschool, or child care centers before September 1, 1995 and who previously provided written certification from the diagnosing physician that the pupil had mumps disease shall not be required to receive mumps vaccine.

(d) Children who present documented laboratory evidence of mumps immunity shall not be required to receive mumps vaccine.

New Rule R.1990 d.243, effective June 4, 1990 (operative September 1, 1991).
See: 21 N.J.R. 3897(a), 22 N.J.R. 1766(a).
Text on providing immunizations recodified to 4.15 and new rule added on mumps vaccine.
Amended by R.1995 d.201, effective April 3, 1995.
See: 27 N.J.R. 270(a), 27 N.J.R. 1417(a).

8:57–4.15 Haemophilus influenzae type b (Hib) conjugate vaccine

(a) Every child from 12 months to 59 months of age enrolling in any child care center or preschool facility after September 1, 1995, shall have received at least one age-appropriate dose of a separate or a combination Hib conjugate vaccine.

(b) Every child from two months to 11 months of age enrolling in a child care center after September 1, 1995 shall have received a minimum of two age-appropriate doses of a separate or a combination Hib conjugate vaccine, or fewer as appropriate for the child's age.

New Rule, R.1995 d.201, effective April 3, 1995.
See: 27 N.J.R. 270(a), 27 N.J.R. 1417(a).

8:57–4.16 Providing immunization

(a) A board of education and/or a local board of health may provide at public expense, the necessary equipment, materials and services for immunizing children with the following immunizing agents, either singly or in combination:

1. Diphtheria toxoid;
2. Pertussis vaccine;
3. Tetanus toxoid;
4. Measles virus vaccine, live, attenuated;
5. Rubella virus vaccine, live;
6. Poliovirus vaccine;
7. Mumps virus vaccine, live;
8. Haemophilus influenzae type B conjugate vaccine;
9. Other immunizing agents when specifically authorized to do so by the State Department of Health.

As amended, R.1978 d.244, effective July 24, 1978.
See: 10 N.J.R. 246(b), 10 N.J.R. 334(a).
Amended by R.1990 d.243, effective June 4, 1990 (operative September 1, 1991).
See: 21 N.J.R. 3897(a), 22 N.J.R. 1766(a).
Text on mumps vaccine deleted; text on providing immunizations recodified from 4.14.
Annotations under old 4.15 Mumps vaccine are as follows:
R.1978 d.244, filed July 24, 1978, effective September 1, 1979.
See: 10 N.J.R. 246(b), 10 N.J.R. 334(a).
As amended, R.1981 d.502, effective January 4, 1982.
See: 13 N.J.R. 738(a), 14 N.J.R. 45(c).
Repealed rule concerning effective date of September 1, 1975 and recodified mumps vaccine from 8:57–4.16.
Amended by R.1985 d.264, effective June 3, 1985.
See: 17 N.J.R. 358(a), 17 N.J.R. 1414(a).
Text amended from "six years of age or younger" to "January 1, 1973".
Repealed by R.1990 d.243, effective June 4, 1990 (operative September 1, 1991).
See: 21 N.J.R. 3897(a), 22 N.J.R. 1766(a).
Text was Mumps vaccine.
Amended by R.1995 d.201, effective April 3, 1995.
See: 27 N.J.R. 270(a), 27 N.J.R. 1417(a).

8:57–4.17 Emergency powers of the State Commissioner of Health

(a) In the event that the State Commissioner of Health or his or her designee determines either that an outbreak or threatened outbreak of disease or other public health immunization emergency exists, the Commissioner or his or her designee may issue either additional immunization requirements to control the outbreak or threat of an outbreak or modify immunization requirements to meet the emergency.

(b) All children failing to meet these additional requirements shall be excluded from a school, preschool, or child care center until the outbreak or threatened outbreak is over.

(c) These requirements or amendments to the requirements shall remain in effect until such time as the State Commissioner of Health or his or her designee determines that an outbreak or a threatened outbreak no longer exists or the emergency is declared over, or for three months after the declaration of the emergency, whichever one comes first. The State Commissioner of Health or his or her designee may redeclare a state of emergency if the emergency has not ended.

R.1981 d.502, effective January 4, 1982.
See: 13 N.J.R. 738(a), 14 N.J.R. 45(c).
New Rule. Old 4.16 recodified to 4.15.
Emergency amendments, R.1985 d.40 effective January 22, 1985 (expires March 22, 1985).
See: 17 N.J.R. 483(a).
Substantially amended.
Readopted, R.1985 d.195, effective March 25, 1985.
See: 17 N.J.R. 483(a), 17 N.J.R. 955(a).
Readoption of emergency amendment. Executive Order 66(1978) expiration date July 18, 1988.
Amended by R.1990 d.243, effective June 4, 1990.
See: 21 N.J.R. 3897(a), 22 N.J.R. 1766(a).
Exclusion requirements clarified.
Amended by R.1995 d.201, effective April 3, 1995.
See: 27 N.J.R. 270(a), 27 N.J.R. 1417(a).

8:57–4.18 Optimal immunization recommendations

The specific vaccines and the number of doses required under this subchapter are intended to establish the minimum vaccine requirements for child care center, preschool, or school entry and attendance in New Jersey. Additional vaccines or vaccine doses are recommended by the State Department of Health, in accordance with the guidelines of the American Academy of Pediatrics (AAP) and the Advisory Committee on Immunization Practices (ACIP) for optimal immunization protection and may be administered, although they are not required for school attendance.

New Rule, R.1990 d.243, effective June 4, 1990.
See: 21 N.J.R. 3897(a), 22 N.J.R. 1766(a).
Amended by R.1995 d.201, effective April 3, 1995.
See: 27 N.J.R. 270(a), 27 N.J.R. 1417(a).

SUBCHAPTER 5. CONFINEMENT OF PERSONS WITH TUBERCULOSIS

Authority

N.J.S.A. 26:4–2, 26:4–60 et seq. and 30:9–57.

Source and Effective Date

R.1996 d.130, effective March 18, 1996.
See: 27 N.J.R. 3657(a), 28 N.J.R. 1507(a).

8:57–5.1 Purpose and scope

(a) The purpose of these rules is to control the spread of tuberculosis, particularly new forms of multiple drug resistant TB (MDR–TB), by maximizing the use of currently available and highly effective treatments.

(b) These rules apply to persons who have active TB disease or who are suspected by a health care provider or local health officer of having active TB disease.

(c) Local health officers are primarily responsible for implementation of these rules. Physicians and other providers of health care services, including, but not limited to, hospital administrators and emergency medical technicians, also have responsibilities under these rules.

(d) Local health officers in areas where the person frequents or receives care may take any action authorized under these rules if the local health officer determines that they are necessary for the health of the person or the public. Such local health officers shall notify the local health officer with primary responsibility, within 72 hours, of any actions taken under these rules.

(e) The guiding principles underlying the implementation of these rules are:

1. To protect the public from the spread of active TB disease; and

2. To treat persons with active TB or suspected TB in the least restrictive environment.

8:57–5.2 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Active TB" means that:

1. A person has a sputum smear or culture taken from a pulmonary or laryngeal source and has tested positive for tuberculosis, and the person has not completed an appropriate course of medication for tuberculosis; or

2. A smear or culture taken from an extra-pulmonary source on a person has tested positive for tuberculosis and there is clinical evidence or clinical suspicion of pulmonary tuberculosis disease, and the person has not completed an appropriate prescribed course of medication for tuberculosis; or

3. In those cases where sputum smears or cultures are unobtainable, the radiographic evidence, in addition to current clinical evidence and/or laboratory tests, is sufficient to establish a medical diagnosis of pulmonary tuberculosis for which treatment is indicated.

"Appointment keeping rate" means the number of kept appointments divided by the number of scheduled appointments.

"Chief of TB Control" means the Chief of the TB Control Program in the Division of Epidemiology, Environmental, and Occupational Health Services, New Jersey Department of Health, or his or her designee.

"Clinically suspected active TB" means a condition in which the person presents a substantial likelihood, as determined by a health care provider, of having active tuberculosis that is infectious, based upon epidemiologic evidence, clinical evidence, x-ray readings, or laboratory test results.

"Close contact" means a person, as identified by a health care provider or his or her designee or by an agent of the State or local health department, who shares common living, recreational, working, transportation or other areas with a person with infectious tuberculosis such that the frequency and/or proximity of those contacts may cause transmission of tuberculosis between the two persons.

"Commissioner" means the Commissioner of the Department of Health, or his or her designee.

"Compliance" means that a person takes 80 percent or more of his or her prescribed TB medication. The term "compliance" is equivalent to the term "adherence," a term often used by the Centers for Disease Control and Prevention.

"Designated commitment facility or unit" means a health care facility selected by the Commissioner of Health that has submitted a proposal to provide one or more of the following when involuntary commitment is required under these rules: space for involuntary commitment; space and clinical program for involuntary examination; and/or space and clinical program for commitment and facilities for hearings under this subchapter.

"Directly observed therapy (DOT)" means a methodology for ensuring compliance with medication directions in which a health care provider or trained designee witnesses the person take his or her prescribed medications.

"Health care provider" means a person who is directly involved in the clinical diagnosis of and the prescribing of medication for individuals. These individuals would include physicians, nurses, nurse practitioners, clinical nurse specialists, and/or physicians assistants.

"Infectious tuberculosis" means the stage of tuberculosis, as determined by laboratory, radiologic, epidemiologic or clinical findings, where mycobacterial organisms are capable of being expelled into the air by a person.

"Least restrictive alternative" means the intervention that limits the person's activities the least, balanced against the risk to the public and individual persons based on the likelihood that tuberculosis infection would be spread.

"Local health officer" means a holder of a license as a health officer as issued by the State Department of Health in accordance with applicable laws, or his or her duly authorized representative. Unless otherwise indicated, the local health officer who has primary responsibility under these rules is the local health officer of the jurisdiction in which the patient resides.

"Loss of contact" means that two documented attempts on different days and at different times, by a health care provider or his or her designee or by an agent of the Department of Health or a local health officer or his or her designee, to conduct a face to face meeting with a person fail because the individual was not at his or her last known residence or designated location. In the case of persons with no current address, last known residence refers to a discrete geographic area in a community in which the person was last seen with some degree of regularity.

"Medical director" means the physician with clinical responsibility for a designated commitment facility.

"Multiple drug resistant tuberculosis (MDR–TB)" means a form of TB that is resistant to at least isoniazid and rifampin as included in the Joint Statement of the American Thoracic Society and the Centers for Disease Control and Prevention: "Treatment of Tuberculosis and Tuberculosis Infection in Adults and Children", March 1993, as amended and supplemented.

"Social resources" means services which allow the person to successfully complete the prescribed course of treatment, including, but not limited to, food, housing, transportation, and communication.

8:57–5.3 Reportable events

(a) Every health care provider attending any person diagnosed with active tuberculosis disease or clinically suspected active tuberculosis shall, within 24 hours, report by telephone or fax, and in writing within 72 hours, the following events to the appropriate local health officer(s) and the Chief, TB Control Program, Division of Epidemiology, Environmental, and Occupational Health Services, CN 369, Trenton, NJ 08625–0369, telephone (609) 588–7522, fax (609) 588–7562:

1. All diagnosis(es) of persons with active tuberculosis disease, as well as the name, telephone number, and address of the case manager assigned to each person;

2. Refusal or failure to submit to a TB diagnostic examination by persons who are clinically suspected of having tuberculosis; and

3. Loss of contact with any person with active tuberculosis.

(b) Every health care provider attending any person diagnosed with active tuberculosis disease shall, within 72 hours, report in writing the following events to the appropriate local health officer(s) and the Chief, TB Control Program, Division of Epidemiology, Environmental, and Occupational Health Services, CN 369, Trenton, NJ 08625–0369, fax (609) 588–7562:

1. Persons newly enrolled in a prescribed treatment plan;

2. Persons terminated from a prescribed treatment plan; and

3. Persons discharged from tuberculosis diagnosis or treatment commitment pursuant to medical or court orders.

(c) The local health officer shall report in writing, within 72 hours, the following events to the Chief, TB Control Program, Division of Epidemiology, Environmental, and Occupational Health Services, CN 369, Trenton, NJ 08625–0369:

1. A person missing an appointment, as ordered by the local health officer in accordance with N.J.A.C. 8:57–5.5;

2. Detention to prevent loss of contact pending court order in accordance with N.J.A.C. 8:57–5.7; and

3. Orders issued by the local health officer to commit a person for TB diagnosis or treatment.

(d) Reports of events listed in (a) through (c) above shall include, but not be limited to, the person's name, address or last known location, phone number, date, and specific circumstances of the reported event, and the health care provider's name, address, and phone number.

(e) A person who has knowledge or reasonable cause to believe that a person has tuberculosis disease shall not be subject to civil, administrative, disciplinary, or criminal liability for reporting in good faith an event pursuant to these rules.

8:57–5.4 Case management and outreach services

(a) The health care provider shall assign a case manager to each person with active tuberculosis. The case manager may be the health care provider or his or her designee. The Chief of TB Control shall approve the case manager for each person with active TB who receives services in a public health clinic. The case manager shall have the overall responsibility for monitoring and ensuring the person's compliance with his or her treatment plan. The case manager shall also assist the person in obtaining services from appropriate social service agencies.

(b) The case manager shall provide educational services to persons with active tuberculosis. Educational services shall include, but not be limited to, information regarding:

1. How TB is transmitted;

2. How to prevent the spread of TB;

3. How to take medications;

4. The effects of TB if not adequately treated;

5. The importance of completing the prescribed course of treatment;

6. The person's responsibility in curing his or her disease;

7. The legal consequence of noncompliance with the treatment protocol and infection control; and

8. The causes and consequences of MDR–TB.

(c) The Chief of TB Control shall direct the provision of necessary outreach services. Outreach services may include, but not be limited to, interviewing and educating persons with active and clinically suspected active tuberculosis, and their close contacts. The local health officer shall provide assistance in outreach activities, as requested by the Chief of TB Control.

(d) If, in the judgment of his or her health care provider, a person with active tuberculosis or clinically suspected active tuberculosis is incapable of understanding in English any communication required by these rules, the health care provider or, at his or her direction, the case manager, shall notify the local health officer who shall arrange for such communication in a language understood by the person. If, within three business days of receipt of such notice, the local health officer documents that an appropriate translation is not available at the local level, he or she shall notify the Chief of TB Control who shall arrange for such translation. The determination of the Chief of TB Control as to the appropriate communication shall be final. This provision shall apply only to communications required by these rules and shall not apply to any other communication arising in the context of the person's treatment.

8:57–5.5 Diagnostic examinations

(a) Where a health care provider, based on direct observation, believes that a person has clinically suspected active tuberculosis, the health care provider shall schedule an appointment for a diagnostic examination to be conducted within five business days of such observation.

(b) Persons with clinically suspected active tuberculosis shall be informed in writing by their health care provider that:

1. A diagnostic examination is required by law for persons with clinically suspected active TB;

2. Failure to keep two scheduled appointments for such an examination shall result in involuntary detention for the purpose of conducting the examination; and

3. Transportation assistance to the examination may be available from the local health officer.

(c) A person with clinically suspected active tuberculosis who does not keep his or her appointment shall be reported to the local health officer who shall make and document at least two additional attempts to schedule an appointment. An attempt to contact is defined as going to the person's primary residence or last known whereabouts to establish a face-to-face contact. Attempts should be made on different days and at different times to maximize the opportunity to obtain a face-to-face contact.

(d) A person with clinically suspected active tuberculosis who has either specifically communicated refusal to submit to a diagnostic examination, or who has missed two scheduled appointments for a diagnostic examination and who has not had a face-to-face contact with the local health officer after two attempts, may, consistent with the provisions at N.J.A.C. 8:57–5.7, be committed to a commitment facility or unit for a diagnostic examination. The person shall be advised of his or her rights under N.J.A.C. 8:57–5.9 before or concurrently with commitment.

(e) Where a health care provider has knowledge that a person has infectious tuberculosis, the health care provider shall notify the local health officer within 24 hours of the positive report. The local health officer shall then determine whether there are any close contacts who must be examined for tuberculosis.

1. If a close contact is identified who resides within the health officer's jurisdiction, the local health officer shall notify that individual and shall schedule a diagnostic examination within 10 business days of said notification.

2. If a close contact resides outside the local health officer's jurisdiction, the local health officer shall notify the Chief of the TB Control Program, Division of Epidemiology, Environmental, and Occupational Health Services, CN 369, Trenton, NJ 08625, fax (609) 588–7562. Such notification shall be made in writing within three days of the local health officer's knowledge of the close contact.

i. If the close contact resides in New Jersey, the Chief of TB Control shall notify the appropriate local health official who shall be responsible for notifying the individual and scheduling an appointment for a diagnostic examination.

ii. If the close contact resides outside of New Jersey, the Chief of TB Control, shall notify the appropriate state authorities.

iii. The residence of the close contact is defined as the contact's address, last known whereabouts, or a discrete geographic area in a community in which the person was last seen with some degree of regularity.

3. The appropriate local health officer shall schedule a diagnostic examination for tuberculosis for each close contact. The local health officer shall notify the contact individual of the time, place, purpose, and mandatory nature of the examination. Notification shall be made in all cases by certified mail, and also by telephone whenever possible.

4. If the contact does not keep the scheduled appointment, the local health officer shall provide for rescheduling the examination within 72 hours of the missed appointment. Notification of the rescheduled appointment shall be made in all cases by certified mail, return receipt requested, and by telephone or face-to-face contact whenever possible.

5. If the contact does not keep the rescheduled appointment, the local health officer shall make and document at least two additional attempts to reschedule an appointment for a diagnostic examination. An attempt to contact is defined as going to the person's primary residence or last known whereabouts to establish a face-to-face contact. Attempts should be made on different days and at different times to maximize the opportunity to obtain a face-to-face contact.

6. A contact who has either specifically communicated refusal to submit to a diagnostic examination, or who has missed two scheduled appointments for a diagnostic examination and who has not had a face-to-face contact with the local health officer after two attempts, may, consistent with the provisions at N.J.A.C. 8:57–5.7, be committed to a commitment facility or unit for a diagnostic examination. The contact shall be advised of his or her rights under N.J.A.C. 8:57–5.9 before or concurrently with commitment.

(f) A person who is committed solely for the purpose of a diagnostic examination shall not continue to be committed beyond the reasonable period of time, with the exercise of all due diligence, required to make a medical determination of whether the person has active or infectious tuberculosis. In no event shall any person be committed for the purpose of making a diagnosis for more than five calendar days.

(g) A diagnostic examination for a person with active, infectious, or clinically suspected active tuberculosis shall consist of at least an appropriate physical examination, a chest x-ray, and a mycobacterial test. A diagnostic examination for a close contact shall consist of at least a Mantoux tuberculin skin test and, if medically appropriate, a chest x-ray.

8:57–5.6 Clinical management of TB; outpatient basis

(a) Where a person is diagnosed with active tuberculosis, the health care provider shall immediately develop and implement a prescribed outpatient treatment plan. The person's case manager shall have the overall responsibility for monitoring and ensuring the person's compliance with his or her treatment plan.

(b) Each outpatient treatment plan shall begin with 10 doses of medication under directly observed therapy (DOT). After 10 doses of medication have been directly observed, the health care provider shall evaluate the person to determine whether he or she is able and willing to follow an unobserved outpatient treatment plan or whether DOT should continue. Persons no longer on DOT shall have their medication monitored by his or her health care provider at least once a week to determine medication compliance, evaluate clinical improvement, and assess the person for any side effects to the medication(s).

(c) If, at any time, the health care provider has reason to believe that an individual is thereafter, either unable or unwilling to follow a prescribed unobserved outpatient treatment plan, the health care provider shall request the local health officer to order DOT. Persons on unobserved therapy shall maintain an appointment keeping rate of 80 percent or better as a proxy measure of medication-taking compliance.

(d) Patients on DOT shall be informed by their case manager and health care provider that DOT services will be available at a prescribed time and place. DOT patients shall be informed that they may request a reasonable change in the time and place of their DOT. Changes in time and place shall be made by the case manager based on the patient's needs and the availability of resources.

(e) A health care provider shall recommend to the local health officer that the order for DOT be rescinded if the health care provider determines that the person no longer has active tuberculosis or the person is able and willing to comply with a prescribed unobserved treatment plan. The local health officer shall base his or her decision to rescind DOT on the health care provider's recommendation, the patient's record, and, if deemed necessary by the local health officer, independent review by another health care provider.

8:57–5.7 Grounds for commitment

(a) In accordance with N.J.S.A. 30:9–57, the Commissioner of Health, or his or her designee, or a local health officer in consultation with the Chief of TB Control, may make application in the Superior Court of New Jersey for an Order of Commitment in those instances where:

1. A person with clinically suspected active tuberculosis has clearly expressed refusal to comply, or has failed to

comply, with the diagnostic examination requirements as set forth at N.J.A.C. 8:57–5.5;

2. A close contact of a person with active tuberculosis has clearly expressed refusal to comply, or who has failed to comply, with the diagnostic examination requirements as set forth at N.J.A.C. 8:57–5.5;

3. A person with active tuberculosis has not complied with an order for DOT. Compliance is defined as taking 80 percent of the prescribed medication;

4. A person with active TB is unable or unwilling to comply with a prescribed treatment regimen and/or infection control requirements;

5. A person with infectious MDR–TB is unable or unwilling to comply with infection control requirements; or

6. The Commissioner, or his or her designee, has determined that the public health, or the health of any other person, is endangered by an active case of TB or by a clinically suspected active case of TB.

(b) Persons sought to be committed under this section shall be advised of these reasons for the proposed commitment and shall be granted an opportunity for a hearing, as set forth at N.J.A.C. 8:57–5.8 and 5.9.

8:57–5.8 Hearing process

(a) A person deemed committable pursuant to the criteria set forth at N.J.A.C. 8:57–5.7 may, upon receiving proper notice and hearing, be committed to a hospital or institution which has been designated by the Commissioner of Health, or his or her designee, for the care and custody of persons afflicted with tuberculosis.

(b) In accordance with N.J.S.A. 30:9–57, the person to be committed shall, prior to commitment, be afforded a hearing in the Superior Court. A copy of the applicable rule(s), the reasons for the proposed commitment, and notice of the time and place of the hearing shall be served upon the person to be committed at least two days prior to the hearing. Commitment may occur upon a showing by the Commissioner, or his or her designee, that the person to be committed meets one or more of the criteria set forth at N.J.A.C. 8:57–5.7.

(c) In those instances where a physician has made a diagnosis of active tuberculosis or a preliminary diagnosis of clinically suspected active tuberculosis, as defined at N.J.A.C. 8:57–5.2, and the Commissioner, or his or her designee, or the local health officer has reason to believe that the person poses a risk of flight, that person may be temporarily detained pending an expedited commitment hearing in the Superior Court. Risk of flight means that there is reason to believe that the person would not appear at a scheduled commitment hearing.

(d) In no event shall any person be committed for more than 90 days from the date of the original order without further court review being sought by the Commissioner, or his or her designee, or the local health officer. The Commissioner, or his or her designee, or the local health officer, shall seek further court review within 90 days of each subsequent court order.

8:57–5.9 Due process

(a) At any hearing conducted pursuant to this subchapter, a person shall have the following due process rights:

1. Written notice detailing the grounds and underlying facts of the matter;

2. The right to have counsel present at the hearing and, if indigent, the right to appointed counsel; and

3. The right to be present at a court hearing, to cross examine, and to present witnesses, which rights may be exercised through telecommunication technology.

8:57–5.10 Discharge plan

(a) When the medical director of the commitment facility, or his or her designee, has determined that a person no longer poses a reasonable risk of transmitting any form of tuberculosis and that the person is able and willing to comply with his or her discharge plan, defined below, the medical director of the commitment facility, or his or her designee, shall, within 24 hours, request the local health officer or the court who issued the commitment order to terminate the order. This request shall include a copy of the discharge plan. The determination that a person no longer poses a reasonable risk of transmitting tuberculosis shall be based on the following factors:

1. Three consecutive negative sputum smears taken at medically appropriate intervals; and

2. Significant reduction of symptoms.

(b) The discharge plan shall contain, at a minimum:

1. The name and address of the individual committed;

2. A detailed description of the prescribed case management plans;

3. A description of the person's living situation, including, but not limited to, source of support, persons living in the same household, next of kin, and arrangements with community organizations;

4. The name and address of a health care provider(s) who will provide necessary care, including, but not limited to, assignment of a case manager, clinical case management, DOT and other services necessary to implement the prescribed treatment plan; and

5. The date and time of at least one scheduled appointment with the health care provider(s).

(c) The local health officer, in consultation with the Chief of TB Control, shall review the discharge plan within three business days of receiving a copy of same, taking into consideration the language of the order of commitment, the principle of least restrictive alternatives, and the medical and social resources available to the person. If the local health officer disagrees with the terms of the discharge plan, he or she shall so notify the medical director of the commitment facility, in writing, including the reasons for disagreement with the discharge plan, no later than three business days after receipt.

(d) The local health officer shall keep the discharge plan on file for five years.

8:57–5.11 Commitment facilities

(a) The Commissioner, or his or her designee, shall designate sufficient commitment facilities or commitment units of facilities from among those facilities submitting proposals in accordance with (b) below.

(b) Proposals shall include, at a minimum:

1. Medical services available to TB patients including diagnostic services and medical care for non-TB related illnesses;

2. The qualifications of professional medical staff providing services to TB patients;

3. The security plan, policies and procedures for proposed TB services;

4. A quality assurance plan for TB services; and

5. A location for court hearings.

(c) Within 60 days of the adoption of these rules, the Commissioner, or his or her designee, in consultation with the Commissioner of Human Services, shall issue a request for proposals for designation as a commitment facility or commitment unit of a facility.

(d) The Commissioner, or his or her designee, shall consider the following in designating commitment facilities or commitment units of facilities:

1. Geographic incidence and prevalence rates of tuberculosis;

2. Quality and appropriateness of the proposed tuberculosis service;

3. Costs and financial viability of the facility or units;

4. Department of Health records related to licensing and quality assurance; and

5. Other criteria identified in the request for proposals.

8:57–5.12 Procedures for commitment by local health officers

(a) The local health officer may request assistance from the local police department(s) if the local health officer determines that there is a reasonable likelihood that a person will attempt to avoid commitment or detention.

(b) If assistance is requested, the local health officer shall provide the police with the order under which commitment or detention, as the case may be, is authorized. The local health officer may seek assistance of the police before providing a copy of the order.

(c) If assistance is requested, the local health officer shall provide the police department with the name, address or last known location, and description of the physical characteristics of the person.

(d) The local health officer shall make all reasonable attempts to develop, in consultation with the local police department, a protocol for police assistance which includes the types of assistance which may be requested of the local police department and guidance on appropriate situations for use of emergency medical service personnel.

8:57–5.13 Annual report

The Chief of TB Control shall submit to the Commissioner an annual report describing trends in prevalence and incidence of TB and MDR–TB in New Jersey. The report shall also include descriptive statistics showing the frequency and trends of those reportable events set forth at N.J.A.C. 8:57–3. The first report shall be issued 12 months after the effective date of these rules and subsequent reports shall be due annually thereafter.

8:57–5.14 Confidentiality of records

(a) Patient medical information or information concerning reportable events pursuant to any section of this subchapter shall not be disclosed except under the following circumstances:

1. For research purposes, provided that the study is reviewed and approved by the applicable Institutional Review Board, and is done in a manner that does not identify any person, either by name or other identifying data element;

2. With written consent of the person identified;

3. When the Commissioner, or his or her designee, determines that such disclosure is necessary to enforce public health laws or to protect the life or health of a named party, in accordance with applicable State and Federal laws; or

4. Pursuant to a valid court order.

(b) Violation of (a) above may result in penalties as provided for at N.J.A.C. 8:57–5.16.

8:57–5.15 Mandatory exclusion from workplace or school

(a) Pursuant to N.J.S.A. 26:4–2, the local health officer may order that a person with known infectious tuberculosis be excluded from attending his or her place of work or school, or be excluded from other premises where the local health officer determines, after a review of the facts and circumstances of the particular case, that such an action is necessary to protect the public health.

(b) If a person excluded from a work place or school, pursuant to N.J.S.A. 26:4–2, requests a review of the order, the local health officer shall make an application for a court order authorizing such exclusion within five business days after such request. After any such request, exclusion shall not continue more than 10 business days without a court order. In no case shall a person be excluded from a workplace, school, or other premises for more than 60 days without a court order authorizing such exclusion. The local health officer shall seek further court review of such exclusion within 90 days of the original court order or each subsequent court order.

(c) In any court proceeding under (b) above, the local health officer shall prove each required element for such exclusion by clear and convincing evidence.

(d) The elements for an order for exclusion issued by a local health officer under this section are:

1. Documentation of medical evidence indicating the presence of infectious tuberculosis and an assessment of the person's medical condition;

2. An individualized assessment of the person's circumstances and/or behavior constituting the basis for the issuance of the order; and

3. The less restrictive alternatives that were attempted and/or the less restrictive alternatives that were considered and rejected, and the reasons such alternatives were rejected.

(e) The local health officer shall rescind the order for exclusion upon documentation by a health care provider that the patient had three negative sputum smears at clinically appropriate intervals and a significant reduction of clinical symptoms. The local health officer may seek independent review by another health care provider if he or she has reason to doubt the primary health care provider's determination.

8:57–5.16 Penalties for violation of rules

Any person who fails to adhere to any provision of this subchapter shall be subject to a fine of $50.00 each day for the first offense and $100.00 each day for the second and any subsequent offenses. All violations by health care providers shall be reported to the appropriate professional licensing authorities and public financing programs.

SUBCHAPTER 6. HIGHER EDUCATION IMMUNIZATION

Authority

N.J.S.A. 18A:61D–1, as amended by P.L. 1994, c.48 (C. 18A:3B–1, et seq.).

Source and Effective Date

R.1995 d.587, effective October 20, 1995.
See: 27 N.J.R. 3631(a), 27 N.J.R. 4701(a).

Subchapter Historical Note

Subchapter 6, Higher Education Immunization, was adopted as Emergency New Rules by R.1995 d.518, effective August 21, 1995, to expire October 20, 1995. See: 27 N.J.R. 3631(a). The concurrent proposal of Subchapter 6 was adopted as R.1995 d.587, effective October 20, 1995, with changes to the provisions of R.1995 d.518, effective November 20, 1995. See: Source and Effective Date.

8:57–6.1 Applicability

(a) This subchapter shall apply to all new or continuing full- and part-time undergraduate and graduate students enrolled in a program of study leading to an academic degree at any public or independent institution of higher education in New Jersey.

(b) Two-year institutions shall apply these rules only to those students entering the college for the first time and registering for 12 or more credit hours of course study per semester/term.

(c) Four-year institutions shall apply the rules to all full- or part-time students enrolled in a program leading to an academic degree.

Petition for Rulemaking.
See: 31 N.J.R. 2275(a), 32 N.J.R. 1255(b).

8:57–6.2 Exemptions

(a) A student shall be exempt from immunization requirements for medical or religious reasons, provided that he or she meets the criteria as set forth at N.J.A.C. 8:57–6.9 and 8:57–6.10, respectively.

(b) In addition, an exemption may be made, at the discretion of the institution, for the following categories of students:

1. Students born before 1957;

2. Students enrolled in a program for which students do not congregate, on campus, whether for classes or to participate in institution-sponsored events, such as those enrolled in programs for individualized home study or conducted entirely via electronic media.

(c) Nothing in this subchapter shall be construed as limiting the authority of a New Jersey institution of higher education to establish additional requirements for student immunizations and documentation that such institution shall determine appropriate and which is recommended by the Advisory Committee on Immunization Practices (ACIP) of the United States Public Health Service.

8:57–6.3 Required immunization; measles

(a) Each student entering college for the first time after September 1, 1995 shall have received two doses of a live measles-containing vaccine, or any vaccine combination containing live measles vaccine, that was administered after 1968. The first dose shall have been administered on or after the student's first birthday and the second dose shall have been administered no less than one month after the first dose.

(b) A student vaccinated with a killed measles-containing vaccine, or an unknown vaccine prior to 1968, shall be revaccinated or produce laboratory proof of measles immunity.

(c) A student who presents documented laboratory evidence of measles immunity shall not be required to receive measles vaccine.

8:57–6.4 Required immunization; mumps

(a) Each student entering college for the first time after September 1, 1995 shall have received one dose of live mumps virus vaccine, or any vaccine combination containing live mumps virus vaccine. The vaccine shall have been administered on or after the student's first birthday.

(b) A student who presents documented laboratory evidence of mumps immunity shall not be required to receive mumps vaccine.

8:57–6.5 Required immunization; rubella

(a) Each student entering college for the first time after September 1, 1995 shall have received one dose of live rubella virus vaccine, or any vaccine combination containing live rubella virus vaccine. The vaccine shall have been administered on or after the student's first birthday.

(b) A student who presents documented laboratory evidence of rubella immunity shall not be required to receive rubella vaccine.

8:57–6.6 Institutional responsibility for enforcement

(a) All New Jersey institutions of higher education shall require evidence of immunization as a prerequisite to enrollment of all students except those who meet the exemption requirements set forth at N.J.A.C. 8:57–6.2(b), N.J.A.C. 8:57–6.9 and N.J.A.C. 8:57–6.10, or those students enrolled in two-year institutions who are registered for fewer than 12 credit hours per semester/term.

(b) All New Jersey institutions of higher education shall identify to the State Department of Health an institutional official responsible for the administration and enforcement of this subchapter and for the maintenance of immunization records.

(c) All New Jersey institutions of higher education shall enforce student compliance with this subchapter within 60 days of enrollment.

Petition for Rulemaking.
See: 31 N.J.R. 2275(a), 32 N.J.R. 1255(b).

8:57–6.7 Provisional admission

(a) A student may be registered in an institution of higher education on a provisional basis for his or her first term if the required immunization documentation is not available at the time of registration.

(b) Prior to registration for the second term, a student shall either present documentation of immunization or proof of immunity in accordance with the requirements of this subchapter or be reimmunized.

(c) A student in provisional status may be temporarily excluded from classes and from participation in institution-sponsored activities during a vaccine-preventable disease outbreak or threatened outbreak. This decision shall be made by the institution in consultation with the State Commissioner of Health or his or her designee. This exclusion shall continue until the outbreak is over or until proof of the student's immunization or immunity is furnished.

8:57–6.8 Documents accepted as evidence of immunization

(a) The following documents shall be accepted as evidence of a student's immunization history provided that the type of immunization and the date when each immunization was administered is listed:

1. An official school immunization record or copy thereof from any primary or secondary school indicating compliance with the immunization requirements set forth at N.J.A.C. 8:57–6.3, 6.4, and 6.5; or

2. A record from any public health department indicating compliance with the immunization requirements set forth at N.J.A.C. 8:57–6.3, 6.4, and 6.5; or

3. A record or an official college affidavit form signed by a physician licensed to practice medicine or osteopathy in any jurisdiction of the United States or in any foreign country, or any other licensed health professional approved by the New Jersey Department of Health, which indicates compliance with the immunization requirements set forth at N.J.A.C. 8:57–6.3, 6.4, and 6.5.

8:57–6.9 Medical exemptions

(a) A student shall not be required to have any specific immunizations(s) which are medically contraindicated.

(b) A written statement submitted to the institution from a physician licensed to practice medicine or osteopathy in any jurisdiction of the United States, or in any foreign country, indicating that an immunization is medically contraindicated for a specific period of time, and setting forth the reason(s) for the medical contraindication, based upon valid medical reasons as enumerated by the most recent recommendations of the Advisory Committee on Immunization Practices (ACIP) of the United States Public Health Service, shall exempt a student from the specific immunization requirements for the stated period of time.

1. The guidelines identified in (b) above are available from the Advisory Committee on Immunization Practices, U.S. Public Health Service, Centers for Disease Control and Prevention, Atlanta, GA 30333.

(c) The physician's statement shall be retained as part of the student's immunization record and shall be reviewed annually by the institution to determine whether the exemption shall remain in effect for the next year. When the student's medical condition permits immunization, this exemption shall thereupon terminate and the student shall be required to obtain the immunization(s) from which he or she has been exempted.

(d) A student with medical exemptions to receiving specific immunizations may be temporarily excluded from classes and from participating in institution-sponsored activities during a vaccine-preventable disease outbreak or threatened outbreak. This decision shall be made by the institution in consultation with the State Commissioner of Health or his or her designee. This exclusion shall continue until the outbreak is over or until proof of the student's immunization or immunity is furnished.

8:57–6.10 Religious exemptions

(a) A student shall be exempted from mandatory immunization if the student objects thereto in a written statement submitted to the institution, signed by the student, explaining how the administration of immunizing agents conflicts with the student's religious beliefs.

(b) This statement shall be kept by the institution as part of the student's immunization record.

(c) A student with a religious exemption from receiving immunizing agents may be temporarily excluded from classes and from participation in institution-sponsored activities during a vaccine-preventable disease outbreak or threatened outbreak. This decision shall be made by the institution in consultation with the State Commissioner of Health or his or her designee. This exclusion shall continue until the outbreak is over.

8:57–6.11 Institutional records required

(a) All New Jersey institutions of higher education shall maintain records of immunizations on each student in a format either specified or approved by the Department. Each record shall indicate the date of each required immunization, laboratory evidence of immunity, or, where applicable, the requisite documents, as required pursuant to N.J.A.C. 8:57–6.9 or 8:57–6.10 pertaining to any medical or religious exemptions.

(b) All New Jersey institutions of higher education shall maintain immunization record forms in a manner which allows accessibility to health officials, yet insures the confidentiality of the student's other records. Student immunization histories may be entered into an institution's secure electronic database.

(c) All New Jersey institutions of higher education shall, upon request of a student who is transferring to another institution, send the student's original record of immunization, or an authenticated copy thereof, or electronically print out an authenticated copy of the student's immunization history in the same manner as a college transcript, with any attached statements, to the other institution.

(d) All New Jersey institutions of higher education shall, upon request, release to a student his or her immunization records or an authentic electronic printout of that record. Request for such records shall be honored for three years following a student's graduation, termination, transfer, or departure from the institution.

8:57–6.12 Reports to be submitted to the New Jersey Department of Health

(a) A report of the immunization status of students in every institution shall be sent each year to the New Jersey Department of Health. This report shall be submitted by the official designated pursuant to N.J.A.C. 8:57–6.6(b) to be responsible for the administration and enforcement of this subchapter and for the maintenance of immunization records.

(b) The form for the annual immunization status report shall be provided by the New Jersey Department of Health.

(c) The report shall document the total number of students who are specifically covered by this subchapter, the number of students who are vaccinated, the number of students with medical exemptions, the number of students with religious exemptions, and the number of students not receiving required immunizations.

(d) The report shall be submitted by December 1 of the academic year beginning in September of the same year after the review of all appropriate immunization records.

8:57–6.13 Records available for inspection

All institutions shall maintain centralized records of their students' immunization status. Upon 24 hours notice, those records shall be made available for inspection by authorized representatives of the Department of Health or the local board of health in whose jurisdiction the institution of higher education is located.

8:57–6.14 Providing immunization

Each institution may administer the vaccines required by this subchapter to those students who are unable to either obtain acceptable vaccine documentation or obtain the measles, mumps, or rubella vaccines from their own health care providers.

8:57–6.15 Reporting requirements

Each New Jersey institution of higher education shall report the suspected presence of any reportable communicable disease, as identified at N.J.A.C. 8:57–1.3 and N.J.A.C. 8:57–1.4, to the local health officer having jurisdiction over the locality in which such institution is located.

8:57–6.16 Modifications in the event of an outbreak

In the event of an outbreak or threatened outbreak, the State Commissioner of Health, his or her designee, or local health officers may modify the immunization requirements as set forth in this subchapter to meet the emergency. These modifications may include obtaining immunization documentation or requiring specific immunizations for each student not covered by this subchapter. Each student failing to meet these additional requirements may be temporarily excluded from classes and from participation in institution-sponsored activities. This exclusion shall continue until the outbreak is over or until proof of the student's immunization or immunity is furnished.

SUBCHAPTER 7. STUDENT HEALTH INSURANCE COVERAGE

Authority

N.J.S.A. 18A:62–15.

Source and Effective Date

R.1997 d.347, effective August 18, 1997.
See: 29 N.J.R. 2261(a), 29 N.J.R. 3727(a).

8:57–7.1 Purpose and scope

(a) This subchapter is promulgated pursuant to the provisions of N.J.S.A. 18A:62–15, and shall assure that each full-time student attending a public or private institution of higher education in New Jersey obtains and maintains health insurance coverage.

(b) This subchapter shall neither limit the scope of, nor specify the types of, insurance contract benefits necessary to comply with N.J.S.A. 18A:62–15, except those which are specified at N.J.A.C. 8:57–7.2.

8:57–7.2 Coverage

(a) Every person enrolled as a full-time student at a public or private institution of higher education in this State shall maintain health insurance coverage which provides, at a minimum, basic hospital benefits.

(b) The insurance coverage specified at (a) above shall be maintained throughout the period of the student's enrollment as a full-time student.

8:57–7.3 Documentation of coverage

(a) Every student enrolled as a full-time student shall present evidence of the health insurance coverage required at N.J.A.C. 8:57–7.2 to the institution of higher education on an annual basis.

(b) The form of documentation required shall be in a manner prescribed by the institution of higher education.

8:57–7.4 Availability of coverage

(a) All public and private institutions of higher education in this State shall arrange for health insurance coverage on a group or individual basis for purchase by students who are required to maintain coverage pursuant to N.J.A.C. 8:57–7.2.

(b) All public and private institutions of higher education in this State required to arrange for coverage pursuant to this subchapter shall be required to maintain evidence of compliance with (a) above.

8:57–7.5 Inspection of records

(a) Records or other such evidence of compliance required by this subchapter shall be made available for inspection by representatives of the New Jersey Department of Health and Senior Services upon request.

SUBCHAPTER 8. CHILDHOOD IMMUNIZATION INSURANCE COVERAGE

Authority

N.J.S.A. 26:2–137.1.

Source and Effective Date

R.1998 d.434, effective August 17, 1998.
See: 30 N.J.R. 44(a), 30 N.J.R. 3101(a).

8:57–8.1 Purpose and scope

(a) The purpose of this subchapter is to set forth the standards by which carriers shall provide benefits or services for immunizations, to increase access to childhood vaccines and to improve New Jersey's immunization coverage rate among preschool and school-age children.

(b) This subchapter shall apply to every carrier delivering, issuing for delivery or renewing health benefits plans in this State which health benefits plans are not otherwise subject to N.J.S.A. 17B:27A–2 et seq. (the Individual Health Coverage Program) or N.J.S.A. 17B:27A–17 et seq. (the Small Employer Health Benefits Program).

8:57–8.2 Definitions

The following words and terms, as used in this subchapter, shall have the following meanings, unless the context clearly indicates otherwise:

"Advisory Committee on Immunization Practices" or "ACIP" means an advisory committee to the Centers for Disease Control and Prevention (CDC) that is made up of technical experts needed to advise the CDC on determining national immunization schedules and recommendations.

"Carrier" means a hospital service corporation (N.J.S.A. 17:48–1 et seq.), a health service corporation (N.J.S.A. 17:48E–1 et seq.), an insurer authorized to transact a health insurance business pursuant to Title 17B of the New Jersey Statutes, and a health insurance maintenance organization (N.J.S.A. 26:2J–1 et seq.).

"Centers for Disease Control and Prevention" or "CDC" means the Federal agency which is the lead agency in the nation for disease prevention and control, located in Atlanta, Georgia.

"Commissioner" means the Commissioner of the New Jersey Department of Health and Senior Services.

"Deductible" means the amount of covered charges that are paid by the insured before his or her policy pays any benefits for such charges.

"DTP" means a combined vaccine which includes toxoids and antigens to prevent diphtheria, tetanus and pertussis diseases.

"DTaP" means a combined vaccine which includes toxoids and antigens to prevent diphtheria, tetanus and a more purified antigenic component of the *Bordetalla pertussis* (acellular pertussis) to prevent pertussis disease, and which may also reduce the likelihood of an adverse vaccine reaction.

"Health benefits plan" means any policy or contract delivered, issued for delivery or renewed in this State by a carrier that covers hospital or medical services or provides benefits for hospital or medical expenses.

"Hepatitis B immune globulin" or "HBIG" means hepatitis B immune globulin which is a short acting biological substance given only to individuals known to have been recently exposed to hepatitis B disease.

"Hepatitis B surface antigen" or "HBsAG" means a protein or carbohydrate substance which is present on the surface of the hepatitis B virus, and which stimulates the production of antibodies when introduced into the body.

"Hepatitis B virus vaccine" or "HBV" means a vaccine containing antigens to prevent hepatitis B virus disease.

"Immunization" means the immunizing agent itself, as well as the process and procedures associated with immunizing persons to prevent disease.

"Immunobiologics" means antigenic substances, such as vaccines or toxoids, or antibody-containing preparations, such as globulins and antitoxins, from human or animal donors. These products are used for active or passive immunization. The following are examples of immunobiologics: vaccine, toxoid, immune globulin (IG), intravenous immune globulin (IGIV), specific immune globulin, and antitoxin.

"Influenza vaccine" means vaccines that are produced annually to prevent disease from the most prevalent strains of influenza virus circulating in the world or country.

"Medical contraindication" means a condition in a recipient which is likely to result in a life-threatening problem if the vaccine were given.

"Morbidity and Mortality Weekly Report" or *"MMWR"* means a weekly publication issued by the United States Department of Health and Human Services, Public Health Service, Centers for Disease Control and Prevention, Atlanta, Georgia 30333.

"Outbreak" means more than the normally expected number of cases of a disease occurring in a circumscribed location over a specified time period, normally days or weeks.

"Pneumococcal vaccine" means a vaccine which contains antigens to prevent the occurrence of pneumonia in certain high risk populations.

"Post-exposure prophylactic doses" means prescribed amounts of vaccines and/or other medications which are administered to an individual who was, or who has a strong likelihood of having been exposed to a preventable disease.

"Td" means a combination vaccine which includes toxoids to prevent diphtheria and tetanus diseases only. It is normally recommended for older children and adults.

"Vaccines" means those immunizing agents composed of antigenic substances such as a vaccine or toxoid, or an antibody-containing preparation such as globulin when used to actively or passively immunize a person to prevent disease.

8:57–8.3 Immunizations that must be covered

(a) A carrier shall provide benefits or services covering the expenses of immunizations for children as set forth in (b) below, including the costs of immunobiologics and administration of the immunizations, except that nothing in this subsection shall be construed to require a carrier to exceed its negotiated fee or the usual and customary fee for services rendered in the administration of an immunization.

(b) A carrier shall provide services or benefits for:

1. Immunizations which are specified in the "Recommended Childhood Immunization Schedule" published by the U.S. Department of Health and Human Services, Centers for Disease Control and Prevention in the *Morbidity and Mortality Weekly Report,* as amended from time to time, which can be obtained from the Superintendent of Documents, U.S. Government Printing Office, Washington, DC 20402, telephone (202) 512–1800; and

2. All routine childhood vaccines as specified in the "Recommended Childhood Immunization Schedule":

i. In single or combined form;

ii. Pediatric diphtheria tetanus toxoid (DT) when a medical contraindication to DTP or DTaP exists;

iii. Single antigen measles or rubella vaccine, or measles and rubella (MR) vaccine when medically indicated or recommended;

iv. Hepatitis B immune globulin (HBIG) given concurrently with hepatitis B vaccine when medically indicated for newborns of mothers with HBsAG positive status, or unknown HBsAG status, or other close family contacts as determined by known risk factors; and

v. Influenza, hepatitis A, and pneumococcal vaccines as recommended by the CDC for high risk children.

3. Such immunizations as are recommended or mandated, as the case may be, including post-exposure prophylactic doses, in the event that the Commissioner, or his or her designee, declares that an outbreak of a communicable disease exists or is threatened for which an immunization or program of immunizations is available.

(c) Carriers shall provide benefits or services for immunizations to the same extent as for other medical conditions under the health benefits plan, except that no carrier shall require satisfaction of any deductible, in whole or in part, prior to the provision of benefits or services for immunizations to covered children. A carrier may require payment of a co-payment to the extent that the co-payment shall not exceed the co-payment for other similar services, except that no co-payment shall apply to a Medicaid enrolled child participating in either Plan A, Plan B, or Plan C of the New Jersey Medicaid or New Jersey KidCare Programs.

(d) Carriers shall not deny benefits or services for immunizations provided to a covered child at an age that is later than that set forth in the "Recommended Childhood Immunization Schedule" if the immunization is otherwise necessary to complete the schedule of immunizations for that child as specified in the "Recommended Childhood Immunization Schedule."

(e) Carriers shall provide benefits or services for doses which have to be repeated because previous doses received by a covered child are considered invalid by the DHSS due to administration before the medically recommended time, or due to administration prior to the recommended time interval between immunizations.

8:57–8.4 Penalties

(a) Carriers authorized to transact an insurance business in this State pursuant to Title 17 or Title 17B of the New Jersey Statutes that fail to comply with this subchapter shall be subject to penalties or fines available under those statutes, as specified by the Commissioner of Banking and Insurance.

(b) Carriers authorized to transact business in this State pursuant to N.J.S.A. 26:2J–1 et seq. that fail to comply with this subchapter shall be subject to penalties or fines available under N.J.S.A. 26:2J–1 et seq., or as are otherwise available under the laws of this State.