ANN & NATE Levine Academy

Immunization Requirements

TO BE COMPLETED BY PHYSICIAN & RETURNED

This form serves a guide to the Texas Minimum State Vaccine Requirements for Students and the Department of State Health Services. You may use this form to submit your vaccine records or a physician provided form. Please consult with your pediatrician and the departments listed above to determine minimum intervals between doses and catch-up schedules.

Student's Name _____ Date of Birth _____ Grade (Fall of 2023) _____

DTaP *(Diphtheria, Tetanus, Pertussis)*

Dates of Doses	Vaccine Schedule
1. _____	3 months (first dose)
2. _____	5 months (second dose)
3. _____	7 months (third dose)
4. _____	19-43 months (fourth dose)
5. _____	4-6 years (fifth dose)
a. _____	Grade 7
(1 dose, if 5 years have passed since the last dose)	
b. _____	Grade 8
(1 dose, if 10 years have passed since the last dose)	

Polio

Dates of Doses	Vaccine Schedule
1. _____	3 months (first dose)
2. _____	5 months (second dose)
3. _____	19-43 months (third dose)
4. _____	4-6 years (fourth dose)

MMR (Measles, Mumps, Rubella)

Dates of Doses	Vaccine Schedule
1. _____	12-15 months (first dose)
2. _____	4-6 years (second dose)

HEP B Series

Dates of Doses	
1. _____	3 months (first dose)
2. _____	5 months (second dose)
3. _____	19-43 months (third dose)

Varicella

Dates of Doses	Vaccine Schedule
1. _____	16-43 months (first dose)
2. _____	4-6 years (second dose)

Meningococcal

Dates of Doses	Vaccine Schedule
1. _____	11 years (first dose)

HEP A Series

Dates of Doses	Vaccine Schedule
1. _____	12-23 months (first dose)
2. _____	(second dose should be given 6-18 months following first dose)

Early Childhood students only

Hib *(Haemophilus Influenza Type B)*

Dates of Doses	Vaccine Schedule
1. _____	2 months (first dose)
2. _____	4 months (second dose)
3. _____	12-15 months (third dose)

Early Childhood students only

Pneumococcal

Dates of Doses	Vaccine Schedule
1. _____	2 months (first dose)
2. _____	4 months (second dose)
3. _____	6 months (third dose)
4. _____	12-15 months (fourth dose)

Signature of Physician _____ PRINT Physician's Name _____ Date _____

Physician Office Address _____ Physician Office Telephone Number _____

Email form to forms@levineacademy.org or fax to (972) 248-0695.