



**LEVITTOWN PUBLIC SCHOOLS**  
**Levittown Memorial Education Center**  
**150 Abbey Lane**  
**Levittown, New York 11756**



Ms. Michele Ortiz, **Director**  
 World Language, ENL, Nurse Support  
 516-434-7055  
 Central Registration  
 516-434-7058

**CERTIFICATE OF IMMUNIZATION**  
**(To be filled out and signed/stamped by a physician)**

Student's Name	Date of Birth		Grade
	Date	Date	
<b>DPT/DT *</b> 3-5 Doses required			
<b>Tdap</b> 1 dose at 11 years			
<b>POLIO**</b> 3-4doses required			
<b>MEASLES</b> 2 doses required			<b>MUMPS(2)</b>
<b>MMR</b> 2 doses required			<b>RUBELLA (1)</b>
<b>HIB</b> 1-4 doses Pre-K			
<b>HEPATITIS B</b> 3 doses required			
<b>Varicella</b> 2 doses required			
<b>Meningitis***</b>			
<b>Pevnar</b> 1-4 doses – Pre-K			
<b>other (please specify)</b>			

\*3-5 doses: If 4th dose after age 4 only 4 doses required – 3 doses required for grades 6 through 12.  
 All others, 5 doses.

\*\* 3-4 doses: If 3rd dose after age 4 only 3 doses required.

\*\*\*One dose required by the 7<sup>th</sup> grade. 2 doses required by 12<sup>th</sup> grade. 1 dose required if first dose received at age 16 or older.

---

Date Physician's Signature Physician's Stamp