2018 - 2019 Texas Minimum State Vaccine Requirements for Students Grades K - 12

This chart summarizes the vaccine requirements incorporated in the Texas Administrative Code (TAC), Title 25 Health Services, §§97.61-97.72. This document is not intended as a substitute for the TAC, which has other provisions and details. The Department of State Health Services (DSHS) is granted authority to set immunization requirements by the Texas Education Code, Chapter 38.

IMMUNIZATION REQUIREMENTS

A student shall show acceptable evidence of vaccination prior to entry, attendance, or transfer to a child-care facility or public or private elementary or secondary school in Texas.

Vaccine Required (Attention to notes and footnotes)	Minimum Number of Doses Required by Grade Level												Notes
	Grades K - 6th							Grade 7th	Grades 8th - 12th				
	K	1	2	3	4	5	6	7	8	9	10	11	12	
Diphtheria/Tetanus/Pertussis (DTaP/DTP/DT/Td/Tdap)[1]	5 doses or 4 doses							3 dose primary series and 1 Tdap / Td booster *within the last 5 years*	3 dose primary series and 1 Tdap / Td booster *within the last 10 years*					**For K – 6th grade:** 5 doses of diphtheria-tetanus-pertussis vaccine; 1 dose must have been received on or after the 4th birthday. However, 4 doses meet the requirement if the 4th dose was received on or after the 4th birthday. For students aged 7 years and older, 3 doses meet the requirement if 1 dose was received on or after the 4th birthday. **For 7th grade:** 1 dose of Tdap is required if at least 5 years have passed since the last dose of tetanus-containing vaccine. **For 8th – 12th grade:** 1 dose of Tdap is required when 10 years have passed since the last dose of tetanus-containing vaccine. Td is acceptable in place of Tdap if a medical contraindication to pertussis exists.
Polio[1]	4 doses or 3 doses													**For K – 12th grade:** 4 doses of polio; 1 dose must be received on or after the 4th birthday. However, 3 doses meet the requirement if the 3rd dose was received on or after the 4th birthday.
Measles, Mumps, and Rubella[1, 2] (MMR)	2 doses													**For K – 12th grade:** 2 doses are required, with the 1st dose received on or after the 1st birthday. Students vaccinated prior to 2009 with 2 doses of measles and one dose each of rubella and mumps satisfy this requirement.
Hepatitis B[2]	3 doses													For students aged 11 – 15 years, 2 doses meet the requirement if adult hepatitis B vaccine (Recombivax®) was received. Dosage (10 mcg /1.0 mL) and type of vaccine (Recombivax®) must be clearly documented. If Recombivax® was not the vaccine received, a 3-dose series is required.
Varicella[1, 2, 3]	2 doses													The 1st dose of varicella must be received on or after the 1st birthday. **For K – 12th grade:** 2 doses are required.
Meningococcal[1] (MCV4)								1 dose						For **7th – 12th grade**, 1 dose of quadrivalent meningococcal conjugate vaccine is required on or after the student's 11th birthday. **Note:** If a student received the vaccine at 10 years of age, this will satisfy the requirement.
Hepatitis A[1, 2]	2 doses													The 1st dose of hepatitis A must be received on or after the 1st birthday. **For K – 8th grade:** 2 doses are required.

↓ Notes on the back page, please turn over.↓

NOTE: Shaded area indicates that the vaccine is not required for the respective age group.

[1] Receipt of the dose up to (and including) 4 days before the birthday will satisfy the school entry immunization requirement.

[2] Serologic evidence of infection or serologic confirmation of immunity to measles, mumps, rubella, hepatitis B, hepatitis A, or varicella is acceptable in place of vaccine.

[3] Previous illness may be documented with a written statement from a physician, school nurse, or the child's parent or guardian containing wording such as: "This is to verify that (name of student) had varicella disease (chickenpox) on or about (date) and does not need varicella vaccine." This written statement will be acceptable in place of any and all varicella vaccine doses required.

Exemptions

Texas law allows (a) physicians to write medical exemption statements that the vaccine(s) required would be medically harmful or injurious to the health and well-being of the child or household member, and (b) parents/guardians to choose an exemption from immunization requirements for reasons of conscience, including a religious belief. The law does not allow parents/guardians to elect an exemption simply because of inconvenience (for example, a record is lost or incomplete and it is too much trouble to go to a physician or clinic to correct the problem). Schools should maintain an up-to-date list of students with exemptions, so they may be excluded in times of emergency or epidemic declared by the commissioner of public health.

Instructions for requesting the official exemption affidavit that must be signed by parents/guardians choosing the exemption for reasons of conscience, including a religious belief, can be found at www.ImmunizeTexas.com under "School & Child-Care." The original Exemption Affidavit must be completed and submitted to the school.

For children claiming medical exemptions, a written statement by the physician must be submitted to the school. Unless it is written in the statement that a lifelong condition exists, the exemption statement is valid for only one year from the date signed by the physician.

Provisional Enrollment

All immunizations should be completed by the first date of attendance. The law requires that students be fully vaccinated against the specified diseases. A student may be enrolled provisionally if the student has an immunization record that indicates the student has received at least one dose of each specified age-appropriate vaccine required by this rule. To remain enrolled, the student must complete the required subsequent doses in each vaccine series on schedule and as rapidly as is medically feasible and provide acceptable evidence of vaccination to the school. A school nurse or school administrator shall review the immunization status of a provisionally enrolled student every 30 days to ensure continued compliance in completing the required doses of vaccination. If, at the end of the 30-day period, a student has not received a subsequent dose of vaccine, the student is not in compliance and the school shall exclude the student from school attendance until the required dose is administered.

Additional guidelines for provisional enrollment of students transferring from one Texas public or private school to another, students who are dependents of active duty military, students in foster care, and students who are homeless can be found in the TAC, Title 25 Health Services, Sections 97.66 and 97.69.

Documentation

Since many types of personal immunization records are in use, any document will be acceptable provided a physician or public health personnel has validated it. The month, day, and year that the vaccination was received must be recorded on all school immunization records created or updated after September 1, 1991.

TEXAS Health and Human Services | Texas Department of State Health Services

Texas Department of State Health Services • Immunization Unit • MC-1946 • P. O. Box 149347 • Austin, TX 78714-9347 • (800) 252-9152

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Asthma Action Plan

Student's Name_____ Grade_____ Date of Birth:_____ School_____

Inhaler kept in_____ ❑ School clinic ❑ Self-carry

ACTION CONTROL PLAN

Level of Severity ❑ Intermittent ❑ Mild Intermittent ❑ Moderate ❑ Persistent ❑ Severe Persistent ❑ High Risk

Control ❑ Well controlled ❑ Not well controlled ❑ Very poorly Controlled

Triggers ❑ Animals ❑ Pollen ❑ Dust Mites ❑ Viral Respiratory Infections ❑ Mold ❑ Exercise ❑ Weather ❑ Smoke ❑ Other

Allergies _____

Pulse Ox
❑ ≥ 95% normal
❑ Other_____

If student has any of the following symptoms – chest tightness, difficulty breathing, wheezing, excessive coughing, shortness of breath you will do this: Stop activity and help student to a sitting position, stay calm, reassure student, assist student with use of inhaler if they self-carry, escort student to school clinic or call for nurse for immediate assistance. Never send student to clinic alone!!!

GREEN ZONE – DOING WELL

- Breathing is normal
- No cough, wheeze, chest tightness, or shortness of breath during the day or night
- Can do usual activities

And, if a peak flow meter is used,

Peak flow: more than_____
(80 percent or more of best peak flow)

Take these long-term control medicines each day.

Controller Medications	How much to take	When to take it	At School
_____	_____	_____	❑ Yes ❑ No
_____	_____	_____	❑ Yes ❑ No
❑ **Rescue** Medications	❑ 2 or ❑ 4 puffs ❑ 6 puffs	❑ 10 – 20 minutes before exercise	❑ Yes ❑ No
_____	❑ PRN_____hrs	_____	

YELLOW ZONE – ASTHMA IS GETTING WORSE

- Cough, wheeze, chest tightness, or shortness of breath, or
- Waking at night due to asthma, or
- Can do some, but not all, usual activities

-Or-

If pulse Oximeter is used O2 Sat
_____% to_____%

First Add: rescue medicine

_____ ❑ 2 or ❑ 4 ❑ 6 puffs, every _____ Minutes Repeat every _____Minutes for up to 1 hour
(short-acting beta2-agonist) ❑ Nebulizer solution_____Repeat every_____Minutes

Second **If symptoms (and peak flow, if used) return to GREEN ZONE after 1 hour of above treatment:**
❑Continue monitoring to be sure student stays in the GREEN ZONE
-Or-
If symptoms (and or pulse Ox, if used) do not return to GREEN ZONE after 1 hour of above treatment move to RED ZONE

RED ZONE – MEDICAL ALERT! DANGER

- Very short of breath, or
- Rescue medicines have not helped,
- Cannot do usual activities, or
- Symptoms are same or get worse after treatment in Yellow Zone Pulse Oximeter < 93%

First Rescue medicine

❑_____ ❑ 4 or ❑ 6 puffs every _____Minutes or Nebulizer Solution every_____Minutes
(short-acting beta2-agonist)

Second **Call 911 if unable to return action to yellow zone after 15 minutes or less, call 911, and parent/guardian.**

EMERGENCY! ■Trouble walking and talking due to shortness of breath ■Lips or fingernails are blue ■Chest or neck is pulling in while breathing ■Student must bend forward to breathe

Self Administration ❑ By checking this box and signing below, health care provider and parent, give written authorization of permission for this student to self carry and self administer prescription asthma medication during school or at school related events. This includes authorization to coach and discuss this condition and elements of care with health care provider indicated on this form

Date_____Provider Signature_____Provider Printed Name_____Provider Phone_____Fax _____

Parent/Guardian: I give written authorization for the medications listed in the action plan to be administered in school by the nurse or other school members as appropriate.
I consent to communication between the prescribing health care provider/clinic, the school nurse, the school medical advisor, and for asthma management and administration of this medication.

Date_____ Parent/guardian signature_____ Home phone/cell _____Work_____Alternate contact number _____

Nurse Signature:_____Nurse Name:_____Office Phone:_____Fax:_____

Houston Independent School District
Health and Medical Services

Policies Governing Administering Medication During School Hours

The policy of the Board of Education does not authorize Houston school personnel to give medication of any kind. That includes aspirin, similar preparation, or any other drugs.

Nurses and other school personnel, however, can give medication during school hours under the following restrictions. Pupils who are noncontagious, on long-term medication, on preventative medication, or for a prolonged period on medication that cannot under any arrangement be administered other than during school hours may take medication in school. The healthcare provider's statement must be accompanied by written permission of at least one parent.

Healthcare Provider's Request for Administration of Medication at School Building During School Hours

To the principal of: _____ School Date: _____

Name of child: _____ Birthdate: _____

Diagnosis: _____ ❑Infections ❑ Non-Infectious

In order to keep this child in optimal health and to help maintain school performance, it is necessary that medication be given during school hours.

Name of medication: _____ Color (if applicable): _____

Form of medication:

❑tablet ❑ pill ❑ capsule ❑liquid ❑ inhalation ❑ injection*

❑other (specify):_____

(* Injectable medications may be given at school only when the family physician addresses a written request for this service to Director of Health and Medical Services, giving detailed information concerning the administration of the medication and follow-up. Parents shall be instructed to furnish sterile, disposable syringes and needles which will be returned to the parent for disposal after use.)

Dosage (amount to be given): _____

Frequency: _____

Common side effects: _____

Remarks:_____

This is permission to give medication to my child named above as requested by the physician. I understand that I am giving consent for the school nurse to discuss any concerns regarding this medication with the healthcare provider whose signature appears on this document in order to monitor the healthcare needs of my child.

_____
Parent's Signature

_____
Telephone:

_____
Date:

_____
Facility Name

_____
Physician's/Advanced Practice Nurse Signature

_____
Physician's/Advanced Practice Nurse Name (print or type)

_____
Telephone

EH/ydb REV 07/17/2008

Houston Independent School District
Health and Medical Services

REQUEST FOR PERFORMANCE OF TREATMENT AT SCHOOL BUILDING DURING SCHOOL HOURS

To the Principal of: _____

Name of Child: _____ Birthdate: _____

Address: _____ Telephone: _____

Email Address: _____

PHYSICIAN

Diagnosis: _____

Etiology: _____

Date of onset: _____

Prognosis: _____

Type of procedures to be performed: _____

_____

How often or at what time? _____

_____

Specific recommendations: _____

_____

_____

Precautions, possible untoward reactions, and interventions: _____

_____

Any other pertinent history or physical findings that may affect this procedure: _____

_____

_____ _____

Date Physician's Signature

_____ _____

Physician's Address Type or Print Physician's Name

_____

Telephone Number

PARENT

I understand that I am giving consent for the school nurse to discuss any concerns regarding this treatment with the healthcare provider whose signature appears on this document.

Should my child manifest any unusual symptoms, please contact _____ at _____ and/or my child's physician immediately.

_____ _____

Parent's Signature Telephone number

_____ _____

Date Alternative Telephone number

Physician's request must be renewed at the beginning of each school year. Any change of treatment must be requested in writing by the physician.

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