# VACCINE CHECKLIST

This form is to confirm the applicant has received all the required vaccinations.

## APPLICANT

Address:

City: Province: Postal Code:

Phone: Fax:

## AGE: 12 MONTHS TO 4 YEARS

| Vaccine | Most Recent Date (mm/dd/yyyy) | Vaccine | Most Recent Date (mm/dd/yyyy) |
|---|---|---|---|
| ☐ HEPATITIS B | | ☐ HEPATITIS A | |
| ☐ DTPP-HIB | | ☐ VARICELLA | |
| ☐ PREVNAR | | ☐ FLU SHOT (Nov - Mar Only) | |
| ☐ MMR | | ☐ | |

## DOCTOR AND CLINIC INFORMATION

Clinic:

Address:

City: Province: Postal Code:

Phone: Fax:

Doctor:

Signature:

DOCTOR LYNDON MASCARENHAS
CLAIRHURST MEDICAL CENTRE
1466 BATHURST STREET
SUITE 305
TORONTO ONTARIO M5R 3S3
TEL: 416-960-1014
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