VACCINE CHECKLIST

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

APPLICANT

Address:

City: Province: Postal Code:

Phone: Fax:

AGE: 18 YEARS TO 64 YEARS

Vaccine	Most Recent Date (mm/dd/yyyy)
☐ Td/TdAP (must have had in last 10 yrs)	
☐ MMR (need vaccine date or proof of lab immunity)	
☐ VARICELLA (If had Chicken Pox before then not needed)	
☐ FLU SHOT (Nov - Mar Only)	

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
FAX: 1-866-259-7220
EMAIL: doctorlyndon@LMAS.ca