

# VACCINE CHECKLIST

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

## APPLICANT

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**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **Province:** \_\_\_\_\_ **Postal Code:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

## AGE: OVER 65 YEARS

Vaccine	Most Recent Date (mm/dd/yyyy)	Vaccine	Most Recent Date (mm/dd/yyyy)
<input type="checkbox"/> Td/TdAP	_____	<input type="checkbox"/> PNEUMOCOCCAL	_____
<input type="checkbox"/> VARICELLA	_____	<input type="checkbox"/> FLU SHOT (Nov - Mar Only)	_____

## DOCTOR AND CLINIC INFORMATION

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**Clinic:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City:** \_\_\_\_\_ **Province:** \_\_\_\_\_ **Postal Code:** \_\_\_\_\_

**Phone:** \_\_\_\_\_ **Fax:** \_\_\_\_\_

**Doctor:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

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