

VACCINE CHECKLIST

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

APPLICANT

Name: _____

Address: _____

City: _____

Province: _____

Postal Code: _____

Phone: _____

Fax: _____

AGE: 7 YEARS TO 17 YEARS

Vaccine	Most Recent Date (mm/dd/yyyy)	Vaccine	Most Recent Date (mm/dd/yyyy)
<input type="checkbox"/> Hepatitis B	_____	<input type="checkbox"/> Meningococcal	_____
<input type="checkbox"/> Dtpa (Must have had in the last 10 years)	_____	<input type="checkbox"/> Varicella (Chicken Pox)	_____
<input type="checkbox"/> MMR (Measles, Mumps, Rubella)	_____	<input type="checkbox"/> Flu Shot (Nov - Mar Only)	_____

COVID-19 VACCINE

(As per NEW instructions from CDC, applicants who have not received a COVID-19 vaccine dose in the 12 months prior to the date of the exam are considered due for a dose, effective as of December 08, 2023. This requirement is in place even if the primary series of COVID-19 vaccine are complete/up to date.)

Brand: _____

Dose 1 _____

Dose 2 _____

Dose 3 _____

DOCTOR AND CLINIC INFORMATION

Clinic: _____

Address: _____

City: _____

Province: _____

Postal Code: _____

Phone: _____

Fax: _____

Doctor: _____

Signature: _____