

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: 12 MONTHS TO 4 YEARS

Vaccine	Most Recent Date (mm/dd/yyyy)	Vaccine	Most Recent Date (mm/dd/yyyy)
☐ Hepatitis B	_____	☐ Hepatitis A	_____
☐ Dtp-p-Hib	_____	☐ Varicella (Chicken Pox)	_____
☐ Prevnar	_____	☐ Flu Shot (Nov - Feb Only)	_____
☐ MMR (Measles, Mumps, Rubella)	_____		

DOCTOR AND CLINIC INFORMATION

Clinic: _____

Address: _____

City: _____

Province: _____

Postal Code: _____

Phone: _____

Fax: _____

Doctor: _____

Signature: _____