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)
☐ **Hepatitis B**	_____	☐ **Mengugate**	_____
☐ **Dtpp** (Must have had in the last 10 years)	_____	☐ **Varicella** (Chicken Pox)	_____
☐ **MMR** (Measles, Mumps, Rubella)	_____	☐ **Flu Shot** (Nov - Feb 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: doctor@visadoctor.ca