# 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: 4 YEARS TO 6 YEARS

| Vacine | Most Recent Date (mm/dd/yyyy) | Vacine | Most Recent Date (mm/dd/yyyy) |
|---|---|---|---|
| ☐ **Hepatitis B** | _____ | ☐ **Varicella** (Chicken Pox) | _____ |
| ☐ **Dtpp-Hib** | _____ | ☐ **Flu Shot** (Nov - Feb Only) | _____ |
| ☐ **Prevnar** | _____ | | |
| ☐ **MMR** (Measles, Mumps, Rubella) | _____ | | |

## DOCTOR AND CLINIC INFORMATION

**Clinic:** _____

**Address:** _____

**City:** _____ **Province:** _____ **Postal Code:** _____

**Phone:** _____ **Fax:** _____

**Doctor:** _____

**Signature:** _____

DOCTOR LYNDON MASCARENHAS
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