

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: 18 YEARS TO 64 YEARS

Vaccine	Most Recent Date (mm/dd/yyyy)	Vaccine	Most Recent Date (mm/dd/yyyy)
<input type="checkbox"/> Hepatitis B _____ (only till age 59) (Date of Vaccination or Proof of Lab Immunity)		<input type="checkbox"/> Varicella _____ (Chicken Pox) (If had Chicken Pox before then not needed) (Date of Vaccination or Proof of Lab Immunity)	
<input type="checkbox"/> MMR _____ (Measles, Mumps, Rubella) (Date of Vaccination or Proof of Lab Immunity)		<input type="checkbox"/> Tdap-IPV _____ (Tdap and IPV both required either in combination or separately) (Td must be in the last 10 years)	
<input type="checkbox"/> Flu Shot _____ (Nov - Feb Only)			

DOCTOR AND CLINIC INFORMATION

Clinic: _____

Address: _____

City: _____

Province: _____

Postal Code: _____

Phone: _____

Fax: _____

Doctor: _____

Signature: _____