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: OVER 65 YEARS

Vaccine	Most Recent Date (mm/dd/yyyy)	Vaccine	Most Recent Date (mm/dd/yyyy)
☐ **Tdap-IPV** (Tdap and IPV both required either in combination or separately) (Td must be in the last 10 years)	_____	☐ **Varicella** (Chicken Pox) (If had Chicken Pox before then not needed)	_____
☐ **Pneumococal**	_____	☐ **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: register@visadoctor.ca