

# VACCINE CHECKLIST

This form is to confirm the applicant has received all the required vaccinations.

## APPLICANT

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Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

## AGE: 2 MONTHS TO 11 MONTHS

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Vaccine	Most Recent Date (mm/dd/yyyy)	Vaccine	Most Recent Date (mm/dd/yyyy)
<input type="checkbox"/> Hepatitis B	_____	<input type="checkbox"/> Hepatitis A	_____
<input type="checkbox"/> Dtp-p-Hib	_____	<input type="checkbox"/> Rotavirus	_____
<input type="checkbox"/> Prevnar	_____	<input type="checkbox"/> Flu Shot (Nov - Feb Only)	_____

## DOCTOR AND CLINIC INFORMATION

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Clinic: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

Doctor: \_\_\_\_\_

Signature: \_\_\_\_\_