

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 _____	
☐ Dtp (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: _____