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: 2 MONTHS TO 11 MONTHS

Vacine	Most Recent Date (mm/dd/yyyy)	Vacine	Most Recent Date (mm/dd/yyyy)
☐ Hepatitis B		☐ Hepatitis A	
☐ Dtpp-Hib		☐ Rotavirus	
☐ Prevnar		☐ Flu Shot (Nov - Mar 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
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