

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: 12 MONTHS TO 4 YEARS

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"/> Varicella (Chicken Pox)	_____
<input type="checkbox"/> Prevnar	_____	<input type="checkbox"/> Flu Shot (Nov - Mar Only)	_____
<input type="checkbox"/> MMR (Measles, Mumps, Rubella)	_____		

DOCTOR AND CLINIC INFORMATION

Clinic: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: _____ Fax: _____

Doctor: _____

Signature: _____