

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)
<input type="checkbox"/> Tetanus-Diphtheria (Td/Tdap) (Must have had in the last 10 years)	_____	<input type="checkbox"/> Varicella (Chicken Pox) (If had Chicken Pox before then not needed)	_____
<input type="checkbox"/> Pneumococal	_____	<input type="checkbox"/> Flu Shot (Nov - Feb Only)	_____

DOCTOR AND CLINIC INFORMATION

Clinic: _____

Address: _____

City: _____

Province: _____

Postal Code: _____

Phone: _____

Fax: _____

Doctor: _____

Signature: _____