

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"/> Tdap-IPV (Tdap and IPV both required either in combination or separately) (Td must be in the last 10 years) | _____ | <input type="checkbox"/> Varicella (Chicken Pox) (If had Chicken Pox before then not needed) | _____ |
| <input type="checkbox"/> Pneumococcal | _____ | <input type="checkbox"/> Flu Shot (Nov - Feb Only) | _____ |

DOCTOR AND CLINIC INFORMATION

Clinic: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: _____ Fax: _____

Doctor: _____

Signature: _____