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: 4 YEARS TO 6 YEARS

Vacine	Most Recent Date (mm/dd/yyyy)	Vacine	Most Recent Date (mm/dd/yyyy)
☐ **Hepatitis B**	_____	☐ **Varicella** (Chicken Pox)	_____
☐ **Dtpp-Hib**	_____	☐ **Flu Shot** (Nov - Mar Only)	_____
☐ **Prevnar**	_____		
☐ **MMR** (Measles, Mumps, Rubella)	_____		

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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