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: 18 YEARS TO 64 YEARS

Vaccine	Most Recent Date (mm/dd/yyyy)	Vaccine	Most Recent Date (mm/dd/yyyy)
☐ **Hepatitis B** (only till age 59) (Date of Vaccination or Proof of Lab Immunity)	_____	☐ **Varicella** (Chicken Pox) (If had Chicken Pox before then not needed) (Date of Vaccination or Proof of Lab Immunity)	_____
☐ **MMR** (Measles, Mumps, Rubella) (Date of Vaccination or Proof of Lab Immunity)	_____	☐ **Tetanus-Diptheria** (Td/Tdap) (Must have had in the last 10 years)	_____
☐ **Flu Shot** (Nov - Mar Only)	_____		

COVID-19 VACCINE

Brand:

☐ **Dose 1** _____ ☐ **Dose 2** _____

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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