

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

Vaccine	Most Recent Date (mm/dd/yyyy)	Vaccine	Most Recent Date (mm/dd/yyyy)
<input type="checkbox"/> Hepatitis B	_____	<input type="checkbox"/> Varicella (Chicken Pox)	_____
<input type="checkbox"/> Dtp-p-Hib	_____	<input type="checkbox"/> Flu Shot (Nov - Mar Only)	_____
<input type="checkbox"/> Prevnar	_____		
<input type="checkbox"/> MMR (Measles, Mumps, Rubella)	_____		

COVID-19 VACCINE

Brand: _____

Dose 1 _____

Dose 2 _____

(A single dose of Pfizer-BioNTech COVID-19 Vaccine, Bivalent meets the requirements for applicants 5 years old or older.)

DOCTOR AND CLINIC INFORMATION

Clinic: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone: _____ Fax: _____

Doctor: _____

Signature: _____