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: 12 MONTHS TO 4 YEARS

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

COVID-19 VACCINE

Brand:

☐ **Dose 1**

☐ **Dose 2**

☐ **Dose 3**

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
TEL: 416-960-1014 • FAX: 1-866-259-7220 • EMAIL: register@visadoctor.ca