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: 7 YEARS TO 17 YEARS

Vaccine	Most Recent Date (mm/dd/yyyy)	Vaccine	Most Recent Date (mm/dd/yyyy)
☐ **Hepatitis B**		☐ **Mengugate**	
☐ **Dtpp** (Must have had in the last 10 years)		☐ **Varicella** (Chicken Pox)	
☐ **MMR** (Measles, Mumps, Rubella)		☐ **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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