# 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: 2 MONTHS TO 11 MONTHS

| Vacine | Most Recent Date (mm/dd/yyyy) | Vacine | Most Recent Date (mm/dd/yyyy) |
|---|---|---|---|
| ☐ Hepatitis B | _____ | ☐ Hepatitis A | _____ |
| ☐ Dtpp-Hib | _____ | ☐ Rotavirus | _____ |
| ☐ Prevnar | _____ | ☐ Flu Shot (Nov - Mar Only) | _____ |

## COVID-19 VACCINE (only required if 6 months or older)

**Brand:**

☐ **Dose 1** _____ ☐ **Dose 2** _____

☐ **Dose 3** _____

## DOCTOR AND CLINIC INFORMATION

**Clinic:** _____

**Address:** _____

**City:** _____ **Province:** _____ **Postal Code:** _____

**Phone:** _____ **Fax:** _____

**Doctor:** _____

**Signature:** _____

DOCTOR LYNDON MASCARENHAS
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