

Vaccine Administration Record - MMR

Name _____ Date _____

Employer/Department _____

SSN _____ Med. Record Number _____

PLEASE PRINT

Do you have now or are you being treated for TB? Yes No

Have you ever had a reaction to the MMR vaccine? Yes No

Are you allergic or sensitive to neomycin or eggs? Yes No

Are you currently sick with any acute or chronic illness? Yes No

Do you have a history of blood problems - leukemia, lymphoma, or cancer affecting the bone marrow? Yes No

Are you on any immunosuppressive drugs or steroids or suffer from any immune system disorder? Yes No

Have you received immune globulin or other blood products, or have a transfusion in the past several months? Yes No

If you answered yes to any of the above problems, please provide details: _____

If female, is there any chance you could be pregnant? Yes No

If female, are you breast-feeding? Yes No

I have read or have had explained to me the information about measles, mumps and rubella disease and the MMR vaccine. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of MMR vaccine. I request that the vaccine be given to me.

Signature _____ Date _____

DO NOT WRITE BELOW THIS LINE

Serum Pregnancy Test: Not Applicable Date _____ Result _____

Vaccine Given: MMR Mumps Measles Rubella

Manufacturer _____ Lot # _____ Expiration Date _____

Dose: _____ SQ Site of Injection: Right Deltoid Left Deltoid

Injection Time _____ No reactions after _____ minutes of observation

Reaction, if any: _____ VIS Given? _____

Signature of Vaccine Administrator

Date/Time