Measles, Mumps, and Rubella (MMR) Vaccine Administration Record

Measles, Mumps, and Rubella are acute viral infections that can be prevented with vaccines. The Center for Disease Control and Prevention (CDC) states due to the contact with patients or infected material, health care providers are at risk for exposure to (and possible transmission of) vaccine preventable diseases.

Section I

PLEASE PRINT

I accept the MMR Vaccine and have read the CDC Vaccine Information Statement. VIS 4/20/2012

Last Name	First Name	Date of Birth
Department Name	Department #	Employee ID # **REQUIRED**
Employer Name	Job title	Last 4 SS#

Yes	No	
		Do you currently have any **neurological disorders** (including seizures)?
		Have you had a severe **allergic reaction** to eggs, neomycin, gelatin, or any other components of MMR vaccine?
		Do you have a disease that affects the **immune system**?
		Are you **currently ill**?
		Do you have any kind of cancer?
		Are you being treated with any **steroids**, **radiation or cancer medications**?
		Has a physician instructed you not to have MMR vaccination?
		Have you **received another vaccine** within the past 4 weeks?
		Have you recently had a transfusion or received other **blood products**
		Are you currently **pregnant?** (*CDC recommends to not get pregnant within 4 weeks of receiving the vaccine while the manufacturer of the vaccine recommends 12 weeks*)

I have read or have had explained to me the information on this form about MMR vaccine. I have had a chance to ask questions and these were answered to my satisfaction. I understand the benefits and risks of MMR vaccine. I request that the MMR vaccine be given to me .

Signature: ______________________________ Date: ____________________

Section II.

I decline the MMR vaccination at this time.

I realize I am eligible for MMR immunization and that my refusal of it may put myself, patients, visitors, and families with whom I come in contact with at risk.

Signature: ______________________________ Date: ____________________

Office Use Only

Vaccine #1 Name/Manufacturer: ____________ Lot # ____________ Expiration Date: ____________

Diluent Lot # ____________ Expiration Date: ____________

Site: Left Arm Right Arm Administrator's Signature: ____________ Date: ____________

Vaccine #2 Name/Manufacturer: ____________ Lot # ____________ Expiration Date: ____________

Diluent Lot # ____________ Expiration Date: ____________

Site: Left Arm Right Arm Administrator's Signature: ____________ Date: ____________