# MMR Vaccination

(Measles, Mumps and Rubella)

(Please Print Information Here)

Name (first, last): _____

Department Name: _____ ☐ Volunteer ☐ Employee ☐ Student

Employee ID #: _____ Date of Birth: _____

## Administration of Vaccine

Contraindications:

☐ **Yes** ☐ **No** Severe or life-threatening allergic reactions after a dose of MMR vaccine?

☐ **Yes** ☐ **No** Are you pregnant or think you might be pregnant?

☐ **Yes** ☐ **No** Have you recently had a blood transfusion or received other blood products?

☐ **Yes** ☐ **No** Have you gotten any other vaccines in the past 4 weeks?

☐ **Yes** ☐ **No** Do you have a weakened immune system due to disease or medical treatments and/or have an (immediate) family history of immune system problems?

☐ **Yes** ☐ **No** Are you currently, moderately or severely ill?

☐ Yes, I have received the VIS form dated (**08/6/2021**) and have reviewed the information about the risks and benefits of the MMR vaccine.

☐ Yes, I understand the indications for the vaccine and consent to receiving the MMR vaccine.

**Date (Reviewed VIS): _____ Patient/Employee Signature: _____**

If the above patient/employee is under the age of 18, they must be accompanied by a parent/guardian.

**Parent/Guardian Signature: _____**

**Dose 1 Date of Admin: _____ Time: _____ Site:** ☐ Left Upper Arm ☐ Right Upper Arm **Dose (sticker):**

**Manufacturer: _____ Lot #: _____ Exp. Date: _____**

**Administered/Reviewed By (include full name and title): _____**

**Dose 2 Date of Admin: _____ Time: _____ Site:** ☐ Left Upper Arm ☐ Right Upper Arm **Dose (sticker):**

**Manufacturer: _____ Lot #: _____ Exp. Date: _____**

**Administered/Reviewed By (include full name and title): _____**

## Waiver of Vaccine Only

I release Blessing Hospital from responsibility for ill effects which may result from my failure to comply with the policy. I am aware if I am exposed to Measles/Rubella and have not provided proof of immunity, I will not be able to work from the 10th through the 21st day after exposure or during an outbreak. I am aware if I am exposed to the Mumps and have not provided proof of immunity, I will not be able to work from the 12th through the 26th day after the exposure or during an outbreak.

**Date: _____ Patient Signature: _____**

**Date: _____ Witness Signature: _____**



BLESSING HEALTH