AGE:

THE CITY UNIVERSITY OF NEW YORK
IMMUNIZATION CONSENT FORM FOR MMR VACCINATIONS

COLLEGE	TELEPHONE#	EMERGENCY CONTACT#	
LAST NAME		FIRST	M.I.
□ MALE □ MTF □ FEMALE □ FTM	MOTHER'S MAIDEN NAME	DATE OF BIRTH MONTH DAY YEAR	
ADDRESS	APT.	CITY	STATE ZIP

SCREEN A

ALL INFORMATION PROVIDED WILL BE KEPT CONFIDENTIAL.

PLEASE CHECK THE APPROPRIATE BOX (ES) BELOW

1. Do you have health insurance? □ YES □ NO
2. If yes, who is your health insurance carrier?

□ Health Care Exchange Plan □ Child Health Plus □ Underinsured **Covered by:**
□ Private (ex. Aetna, Blue Cross, HIP) □ Medicaid □ Spouse
□ Sponsored by Parent/Guardian □ Uninsured □ Domestic Partner
□ Other: (specify) _____ □ Employee

SCREEN B

	CIRCLE ONE	
1. Are you feeling sick with anything other than a cold today?	YES	NO
2. Do you have allergies to medications, latex or any vaccine?	YES	NO
a. If so, please list: _____		
b. What type of allergic reaction did you have? _____		
3. Have you received any vaccines in the past four weeks? Which one?	YES	NO
4. Are you taking any medications now?	YES	NO
a. If so, please list: _____		
5. Are you receiving chemotherapy, immunosuppressive therapy or a high dose (<20 mg) or:	YES	NO

YOU MUST AVOID GETTING PREGNANT FOR AT LEAST FOUR WEEKS AFTER RECEIVING THE MMR VACCINE.

1. Are you pregnant now?	YES	NO
2. What was the date of your last menstrual period? _____		

Interviewed by: _____

CONSENT

IF THIS IS YOUR FIRST IMMUNIZATION YOU MUST WAIT 28 DAYS BEFORE HAVING YOUR SECOND IMMUNIZATION.

I have read the information contained in the Vaccine Information Statement about the disease(s) and the vaccine(s). I have had a chance to ask questions which, if any, were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and request that the vaccine(s) indicated below be given to me or to the person named for whom I am authorized as parent, guardian, or long term custodian to make this request.

Yo he leido la Declaracion de Vacunas acerca de la(s) enfermedad(es) y la(s) vacuna(s). He tenido la oportunidad de hacer preguntas las cuales, si hubo algunas, fueron contestadas a mi satisfaccion. Creo que comprendo los beneficios y riesgos de la(s) vacuna(s) y pido que me den la(s) vacuna(s) indicada(s) mas abajo a mi o a la persona nombrada por quien estoy autorizado(a) como padre, guardian, o cuidador por largo tiemp[o para hacer esta peticion.

PATIENT/PARENT SIGNATURE **DATE**
FIRMA DEL PACIENTE/PADRE _____ **FECHA** _____

OFFICE USE ONLY

Vaccine	Dose #	Dosage	V.I.S.	Injection Site	Manufacturer	Lot #	Expiration Date
MMR				LUA/RUA			

Innoculator Signature: **Date:**