

MMR Vaccine Consent Form

Must be 7 years of age or older (patients 7-12 must have a prescription)

Must remain in pharmacy for 10 minutes after injection



PERSONAL INFORMATION

[PLACE RX LABEL HERE]	PATIENT PHONE: () -	
	DATE OF BIRTH: / /	AGE:
	<input type="checkbox"/> FEMALE <input type="checkbox"/> MALE	
	COUNTY:	
	FAMILY DOCTOR:	
	MEDICARE/COMMERCIAL INSURANCE ID:	

SCREENING QUESTIONS

1. Are you currently sick with a fever or any type of infection including tuberculosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Do you have a severe (life-threatening) allergy to eggs or any component (or part) of this vaccine, including Medium 199 (vitamins, amino acids, fetal bovine serum, sucrose, glutamate), recombinant human albumin, neomycin , sorbitol, and hydrolyzed gelatin ?	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Have you ever had a severe (life-threatening) allergic reaction to a previous dose of any vaccine?	<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Do you have cancer, leukemia, lymphoma, HIV/AIDS, or any disease that affects the immune system?	<input type="checkbox"/> Yes <input type="checkbox"/> No
5. In the past 3 months, have you taken medications that weaken your immune system, such as cortisone, prednisone, other steroids, or anticancer drugs, or have you had radiation treatments?	<input type="checkbox"/> Yes <input type="checkbox"/> No
6. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. Do you have a history of thrombocytopenia or thrombocytopenic purpura?	<input type="checkbox"/> Yes <input type="checkbox"/> No
8. Have you received any vaccinations in the past 4 weeks?	<input type="checkbox"/> Yes <input type="checkbox"/> No
9. For women: Are you breastfeeding, pregnant or is there a chance you could become pregnant in the next three months?	<input type="checkbox"/> Yes <input type="checkbox"/> No

Please remain in the pharmacy for 10 minutes following the vaccination. If you leave, you are doing so against medical advice.

I have read or have had explained to me the information in the Vaccine Information Statement about measles, mumps, and rubella (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 and ask that the vaccine be given to me or the person named below for whom I am authorized to make this request. I waive and release all claims I, or anyone claiming by or through me, now have or may hereafter acquire against Dr. James Schwieterman, MD, Schwieterman Pharmacies, and their respective directors, officers, employees, and agents for any damage or injuries if I, or the person named below for whom I am authorized to make this request, contact measles, mumps, rubella, other diseases, or suffer any other adverse reactions following administration of this MMR vaccine. **I understand that I may be held responsible for charges that are not covered by my insurance. I understand that if I do not provide the proper insurance information I may also be held responsible for charges.** For Medicare Recipients: I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party that accepts assignment.



SIGNATURE OF PERSON TO RECEIVE VACCINE OR PERSON AUTHORIZED TO MAKE THE REQUEST (PARENT OR LEGAL GUARDIAN) _____ DATE _____
-----FOR CLINIC/OFFICE USE ONLY-----

IMMUNIZER:		TITLE:	DATE OF IMMUNIZATION:	
VACCINE/MFG/DOSAGE: M-M-R II/Merck/0.5ml	LOT #:	EXP DATE:	SITE OF INJECTION: <input type="checkbox"/> LA/SQ <input type="checkbox"/> RA/SQ	VIS DATE: 4/20/2012
INSURANCE: <input type="checkbox"/> Medicare <input type="checkbox"/> Rx Coverage <input type="checkbox"/> Major Med <input type="checkbox"/> Cash <input type="checkbox"/> _____			STORE:	