

MMR and/or Td Consent Form Campus Health Service

Please check () next to each statement that applies:

- I have received and read the Vaccine Information Statement on ___ MMR ___ Td, including contraindications and side effects.
- Before receiving an injection, I will ask questions of the provider if I have any.
- I understand that I can not take the MMR if I am pregnant or suspect pregnancy, nor can I become pregnant for three months after receiving the MMR.
- I will inform the provider of any allergies prior to receiving the immunization, and note them here:

- I understand that a history of allergic reaction to eggs or the antibiotic neomycin is a contraindication to immunization with many vaccines. I have no history of such reactions.
- I understand that, as with any vaccine or drug, there is a possibility, however remote, that serious allergic reactions or even death could occur.
- I understand that immune deficiency is generally a contraindication to immunization, particularly with live vaccines. I have no immune deficiency disease of which I am aware (e.g., AIDS, leukemia, lymphoma, or other malignancy), nor am I receiving radiation, chemotherapy or steroid treatments.
- I believe I understand the benefits and risks of the vaccine(s) and request that it/they be given to me.
- I agree to remain in the Health Service Clinic for 15-20 minutes following injection to be observed for any sign of adverse reaction.

Patient's signature _____ Date _____

INFORMATION ABOUT PERSON TO RECEIVE VACCINE
(please print)

Last Name	First Name	M.I.	Age
Social Security #		Birth Date	
Address			
City	State	Zip	

FOR CLINIC USE
MMR Td

Clinic identification
Date Vaccinated
Manuf. and lot number
Site of injection

VIS given

FOR CLINIC USE
MMR Td

Clinic identification
Date Vaccinated
Manuf. and lot number
Site of injection

VIS given

Clinician Signature _____