UNIVERSITY OF ILLINOIS SPRINGFIELD
Health Services • BSB 20 • (217) 206-6676 • Fax (217) 206-7779
uishealthservice@uis.edu

MMR Vaccination

Consent & Administration Form

Place sticker:

Student name: _____

UIN: _____

DOB: _____

Age: _____

Telephone: _____

Student address: _____

Current medications

Please list your current medication. Include prescription medication and over the counter medications/drugs:

_____

_____

_____

_____

_____

_____

Allergies

Please list any allergies that you may have:

_____

_____

_____

Medical history

- Before receiving an injection, I will ask questions of the provider if I have any. ☐
- I will inform the provider of any allergies BEFORE receiving the vaccine. ☐
- I do not have an acute illness or infection. ☐
- I have received and read the Vaccine Information Statement on the MMR vaccine, including contraindications and side effects. ☐
- 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 radiations, chemotherapy, or steroid treatments. ☐
- I understand that a history of allergic reactions to eggs or the antibiotic neomycin is a contraindication to vaccine administration. ☐
- I understand that I should report any adverse reactions to Health Services at (217) 206-6676. ☐
- I am not pregnant or breast feeding. ☐
- I believe I understand the benefits and risks of the vaccine(s) and request that it be given to me. ☐
- I agree to remain in the Health Services Clinic for 15-20 minutes following injection to be observed for any sign of adverse reaction. ☐

Student Signature _____ Date: _____/_____/_____

HEALTH SERVICES USE ONLY

VIS form given: ☐ **Yes** ☐ **No** VIS form date: _____/_____/_____ VIS given by: _____

MMR Administration

Has advice been given about the requirements for 2 doses (a full course)? ☐ **Yes** ☐ **No**

Has patient been advised of side effects (inflammation at vaccine site and slight malaise for a day or two)? ☐ **Yes** ☐ **No**

1. Name of vaccine: _____ ☐ **Lot number:** _____ **Expiration date:** _____/_____/_____

Route: ☐ SQ Site of vaccination: ☐ RT deltoid ☐ LT deltoid Nurse Signature: _____ Date: _____

2. Name of vaccine: _____ ☐ **Lot number:** _____ **Expiration date:** _____/_____/_____

Route: ☐ SQ Site of vaccination: ☐ RT deltoid ☐ LT deltoid Nurse Signature: _____ Date: _____

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