82 Norwich-Westerly Road
North Stonington CT 06359

North Stonington Medical Walk-In Center, PC

Phone: (860)599-2469
Fax : (860)599-2830

MMR Vaccination Authorization

Name:_____ Date of Birth_____

Street Address:_____

City:_____ State:_____ Zip:_____

Telephone:_____ SSN:_____

Have you received another vaccination in the past 30 days?	Yes / No
Will you receive another vaccination in the next 30 days?	Yes / No
Are you, or do you plan to become pregnant in the next 3 months?	Yes / No
Are you a nursing mother?	Yes / No
Are you allergic to the antibiotic neomycin?	Yes / No
Are you allergic to eggs?	Yes / No

I have read, or had explained to me, the information sheet relating to the MMR (Measles, Mumps , Rubella shot) . I have been given the chance to ask questions and have been provided answers by this medical practice. I understand the benefits and risks of the vaccination as described in the information sheet provided.

I request the MMR vaccine be given to me (or to the person for whom I am authorized to make this request).

I authorize the release of any medical or other information necessary to process a Medicare or insurance claim.

_____ _____
Signature(or Parent/Guardian Date

For office use only:
Measles Virus Vaccine MSD MMRII Manufacturer:_____

0.5cc SQ Left arm_____ Right arm_____ Lot No.:_____ Exp:_____

MSD Diluent for Live Virus Vaccine: Lot No:_____ Exp:_____

Medical Staff initials:_____ Date:_____