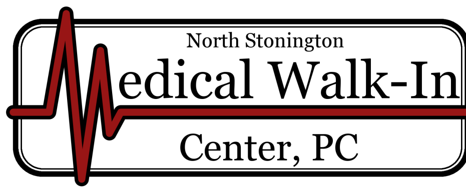
82 Norwich-Westerly Road
North Stonington CT 06359



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:_________