New Paltz
STATE UNIVERSITY OF NEW YORK
Student Health Service ▪ Division of Student Affairs
1 Hawk Drive ▪ New Paltz, NY 12561-2443 ▪ 845-257-3400 ▪ Fax 845-257-3415
healthservice@newpaltz.edu

Student Name: _____ Date of Birth: _____ Student ID# N0_____

Birth Country: _____ Your age: _____ Mother's Maiden Name: _____

MMR Vaccination Screening Questionnaire

For adult patients as well as parents of children to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child **Meningococcal vaccination** today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask us to explain it.

1. Are you sick today? ☐Yes ☐No
2. Are you allergic to neomycin, gelatin, or eggs? ☐Yes ☐No
3. Have you ever had a reaction after receiving a MMR vaccine? ☐Yes ☐No
4. Do you have any chronic illnesses? ☐Yes ☐No
5. Are you receiving immunosuppressive medication such as prednisone, anti-cancer drugs, or immunosuppressive drugs to treat arthritis, dermatitis or colitis? ☐Yes ☐No
6. Do you have a disease that suppresses your immune system such as HIV, Leukemia, Lymphoma, or malignant neoplasm? ☐Yes ☐No
7. Do you bruise easily or have low platelets? ☐Yes ☐No
8. For women: are you pregnant or planning on becoming pregnant? ☐Yes ☐No
   Last Menstrual Period: _____
9. For women: are you breastfeeding? ☐Yes ☐No

MMR Consent:
I have read, or have had explained to me, the information sheet about **MMR vaccination**. I have had a chance to ask questions which were answered to my satisfaction and I understand the benefits and risks of the vaccination as described in the vaccination information sheet.

I request the MMR vaccination to be given to: ☐**Me** **or** ☐**My Child**

_____ _____
Signature of recipient (or parent or guardian) Date

FOR OFFICE USE ONLY:

VACCINE	DATE GIVEN	SITE	MFR.	LOT #	EXP. DATE	VIS DATE	NURSE SIGN
MMR							