MMR Vaccine Consent Form

KNOX PUBLIC HEALTH

Patient Information (Please Print)			
First Name: **MI:** **Last Name:**		**Date of Birth** **Age:**	**Phone #:**
Mailing Address:			**SS# or DL#**
City:	**State:**	**Zip:**	**County:**
Gender:	**Race:**	**Ethnicity:** Hispanic/Latino	Not Hispanic/Latino
Do you live within Mount Vernon city limits? **Yes** **No**			

Insurance Information ___(check here if you do not have health insurance)

Policy Holder's Name (parent/spouse/guardian):

Policy Holder's Birthdate (parent/spouse/guardian):

I have private health insurance _____	**I have Medicare _____**	**I have Medicaid _____**
Name of Primary Plan:	Name of Primary Plan:	Name of Primary Plan
Member ID#	Member ID#	Member ID#
Group #	Group #	Group #
Name of Secondary Plan	Name of Secondary Plan	Name of Secondary Plan
Member ID#	Member ID#	Member ID#
Group #	Group #	Group #

Please answer the following questions		
1. Females Only: Is there a chance you may be pregnant today?	YES	NO
2. Are you sick today?	YES	NO
3. Have you ever had a serious (anaphylactic) reaction after receiving a vaccination?	YES	NO
4. Do you have a weakened immune system?	YES	NO
5. Have you recently received a blood transfusion or received other blood products?	YES	NO
6. Have you received any other vaccines in the last four weeks?	YES	NO

The Knox Public Health or Health Center may keep this record in your medical file. They will record what vaccine was given, date the vaccine was given, the name of the company that made the vaccine, the vaccine special lot number, the signature and title of the person who gave the vaccine, and the address where the vaccine was given. I understand that this information will be released to a state-wide Immunization Registry for the purpose of immunization tracking recall and recording, unless I request otherwise. I have read or have had explained to me the Vaccine Information Sheet regarding the vaccine(s) being received today. I have had a chance to ask questions, and they were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine(s) and ask that the vaccine(s) be given to the person named above for whom I am authorized to make this request. Your medical information is never shared without an authorization to release information. A copy of Knox Public Health's Notice of Privacy Practices (HIPAA) will be provided upon request, and it is also located on our website at www.knoxhealth.com.

Patient/Guardian Signature: _____ Date: _____

Relationship to Patient: _____

Name _____ Date of Birth _____

FOR OFFICE USE ONLY

MMR Vaccine	Vaccine Manufacturer:	**Vaccine Administrator Name:**
__ VFC __ 317 __ Prvt Injection Site: RA LA RL LL __ E-Clinical	Lot #_____ Expiration: _____	_____ **Signature:** _____ **Date:** _____

04/02/2025 LRD