SACRAMENTO STATE

Student Health, Counseling & Wellness Services

2026

M-M-R Vaccination Screening and Consent Form

NAME: _____ BIRTHDATE: _____ SAC STATE ID _____
(First) (Last) (mm-dd-yyyy)

Phone: _____ Gender: _____

For you to be eligible to receive MMR vaccine at this clinic, **answer all questions and sign this consent form**.

Screening Questionnaire	YES	NO
1) Are you sick today?		
2) Do you have allergies to medications, foods, or any vaccine?		
3) Have you ever had a serious reaction after receiving a vaccination?		
4) Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), or asthma, anemia, or other blood disorder?		
5) Do you have cancer, leukemia, AIDS, or any other immune system problem?		
6) Do you take cortisone, prednisone, or other steroids, or anticancer drugs?		
7) Have you had a seizure, brain, or other nervous system problem?		
8) During the past year, have you received a blood transfusion or blood products, or have been given a medicine called immune (gamma) globulin?		
9) Have you received any vaccinations in the past 4 weeks?		

For people who menstruate:	MONTH	DAY	YEAR		
10) When was the first day of your last menstrual period?					
11) Have you had intercourse without using a birth control method since your last menstrual period?					
12) Are you pregnant?					

I have been given a copy and have read, or had explained to me, the information contained on the Vaccination Information Sheet on the diseases and vaccine known as Measles Mumps Rubella (MMR). I have had a chance to ask questions which were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and request that it is given to me.

Signature: _____ **Date:** _____

Office Use Only						
Date	**Vaccine**	**Mfg**	**Lot**	**Exp Date**	**Screened and given IZ by:**	**Site (subcutaneous)**
4/21/26	**M-M-R**	**Merck**			**Sacramento State SHCWS 6000 J St. Sacramento, CA 95819**	**____Left ___Right tricep**