Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Measles, Mumps, Rubella (MMR) Vaccination Consent Form (Outbreak)

If you wish to given consent please fill in parts 1, 2 & 3.

Privacy Statement: HSE staff are aware of their obligation under the Data Protection Acts, 1988 and 2003. The information provided will be included in an Immunisation Database. The HSE will use this information to validate clients, monitor vaccination programmes and provide healthcare.

PART 1. Complete this part with the details of the person being vaccinated (please use block capitals)

Forename: | Middle Name: | **Surname** (Family name):

Personal Public Services Number (PPSN) ☐☐☐☐☐☐☐☐☐☐

(PPSN will be required to manage your immunisation record only)

Date of Birth (DD/MM/YYYY): ____/____/____ Gender (circle as appropriate): Male / Female

Address: ____________________

County: ____________________

GP Name and Address: ____________________

(Your information may be shared with your General Practitioner)

PART 2. Complete this part for vaccination

Have you had any vaccines in the past 4 weeks? Yes ☐ No ☐
Please detail ____________________

Have you had any serious illness in recent years? Yes ☐ No ☐
Please detail ____________________

Are you currently taking medication? Yes ☐ No ☐
Please detail ____________________

Have you ever had a severe reaction to anything including medication or vaccines (including anaphylaxis)? Yes ☐ No ☐
Please detail ____________________

Have you had any illness or condition that increases the risk of bleeding? Yes ☐ No ☐
Please detail ____________________

Are you pregnant? Yes ☐ No ☐
Please detail ____________________

PART 3. Complete this part for consent

Yes, I consent to have myself/the above named person vaccinated to protect against Measles, Mumps and Rubella (MMR).
I confirm by signing this form that I am authorised to give consent on behalf of the above named person. (Anyone over 16 years of age is legally entitled to consent for themselves).
I understand that this vaccine is not recommended during pregnancy.

Signature: ____________________ Date: ____/____/_____ (DD/MM/YYYY)

Name (Please print): ____________________ Tick Appropriate Self ☐ Parent ☐ Guardian ☐

For official use only

Date Given	Batch Number	Injection Site	Prescriber signature & MCRN	Vaccinator signature & PIN/MCRN	Venue
/ /		(circle as appropriate) Left Deltoid Right Deltoid			

Completed by: ____________________ MCRN/PIN: ____________________ (If applicable) Date (DD/MM/YYYY): ______/______/_________

11/2017