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Measles, mumps and rubella (MMR) vaccine Risk Assessment Form

Title: Mr: ☐ Miss: ☐ Ms: ☐ Mrs: ☐ Other: ☐	**D.o.B.:** _ _ / _ _ / _ _	**Age:** _____
Name:	**Home Address:**	
Surname:		
Email:	**Name & Address of GP** (optional)	
Telephone:	**Would you like your GP to be informed of this consultation?** Yes ☐ No ☐	

Please answer the following questions (must be completed by parent or guardian if under 16)

Do you feel unwell, have a temperature or an infection? Yes ☐ No ☐	Do you have thrombocytopenia (low blood platelet count), or have you experienced thrombocytopenia after receiving a previous dose of MMR vaccine? Yes ☐ No ☐
Have you ever had an allergic or anaphylactic reaction to a MMR vaccine or any other vaccine before? *If yes, please describe the reaction* Yes ☐ No ☐	Have you received any blood products such as antibodies (immunoglobulins) in the last 3 months? Yes ☐ No ☐
Do you have any allergies (e.g. egg, antibiotics)? *If yes, please describe the allergy/reaction* Yes ☐ No ☐	Have you been in contact with somebody that had measles in the last 3 days? Yes ☐ No ☐
Do you have any cancer that may affect the immune system? Yes ☐ No ☐	Do you have untreated tuberculosis? Or are you due to have a skin test for possible tuberculosis? Yes ☐ No ☐
Do you have a bleeding disorder, including taking any medication that thins your blood (anticoagulants)? Yes ☐ No ☐	Do you have any neurological problems? *If yes, please provide details* Yes ☐ No ☐
Do you feel any stress related reactions (e.g. feeling faint) when receiving a vaccine? *If yes, please provide details* Yes ☐ No ☐	If you have a child, are they pregnant or is there any possibility they may be pregnant? Yes ☐ No ☐
Are you pregnant, planning pregnancy or is there any possibility that you may be pregnant? Yes ☐ No ☐	Are you currently breast feeding? Yes ☐ No ☐
Are you aware that you should avoid pregnancy for 1 month after receiving the vaccine? Yes ☐ No ☐	Do you have a history or family history of convulsions (fits)? Yes ☐ No ☐
Are you immunosuppressed due to disease or treatment (e.g., HIV)? *If yes, please provide details* Yes ☐ No ☐	Does anyone in your family have an immune disorder? Yes ☐ No ☐
Have you been told by your doctor you have an intolerance to any sugars? *If yes, please provide details* Yes ☐ No ☐	Do you have any bone marrow problems or blood disorders (e.g. Blood dyscrasias)? Yes ☐ No ☐

Please provide details of any recent or past medical history of note

Please list all your current prescription medication including any medication you buy over the counter

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Please answer the following questions (must be completed by parent or guardian if under 16)

Please select all previous vaccines that you have received, and provide dates if known
If any of these *vaccines were administered in the last 4 weeks, please inform your healthcare professional*

Tetanus	☐	Date:	Hepatitis B (1)	☐	Date:	Hepatitis A (1)	☐	Date:
Polio	☐	Date:	Hepatitis B (2)	☐	Date:	Hepatitis A (2)	☐	Date:
Diphtheria	☐	Date:	Hepatitis B (3)	☐	Date:	Japanese encephalitis (1)	☐	Date:
Rabies (1)	☐	Date:	Hepatitis B (Booster)	☐	Date:	Japanese encephalitis (2)	☐	Date:
Rabies (2)	☐	Date:	Typhoid	☐	Date:	Tick-borne encephalitis (1)	☐	Date:
Rabies (3)	☐	Date:	Meningitis ACWY	☐	Date:	Tick-borne encephalitis (2)	☐	Date:
Rabies (Booster)	☐	Date:	Yellow Fever	☐	Date:	Tick-borne encephalitis (3)	☐	Date:
Cholera	☐	Date:	Influenza	☐	Date:	Shingles	☐	Date:
Others (please name)	☐							

Are you going to be travelling?
If yes, please provide details of your planned trip below Yes ☐ No ☐

Country to be visited	Arrival date	Departure date

Please provide the reason for travel

Business	☐	Pleasure	☐	Hajj or other pilgrimage	☐	Visiting friends or relatives	☐
Other (please specify)	☐						

Please select the accommodation you are staying in

Hotel	☐	With friends or relatives	☐	Other (please specify)	☐

Please provide any other trip details you feel we should know

PATIENT CONSENT
I have received information on the risks and benefits of the vaccine and I have had the opportunity to ask questions. The medical information I have provided is true and accurate to the best of my knowledge and I consent to the vaccine being given.

Signature of patient, parent or guardian _____ **Date** _____

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HEALTHCARE PROFESSIONAL USE ONLY	
Non-supply/administration	
I confirm that the patient did NOT receive the medication ☐	**Patient referred to GP** ☐
Reason for non-supply/administration	

HEALTHCARE PROFESSIONAL USE ONLY					
Supply/administration					
Vaccine brand, batch number and expiry date	*Affix vaccine label here or write details*	L deltoid ☐ R deltoid ☐	Intramuscular ☐ Deep SC ☐ (Only for those with a bleeding disorder if the professional is competent with the technique)	Date	Cost
I confirm that the patient is not contraindicated based on the information provided by the PGD ☐					
I have explained the potential warnings and side effects of the treatment to the patient, and requested they report them if they occur ☐					
I have provided the patient with an information leaflet (PIL) for the treatment I am administering, and advised them to read it ☐					
Healthcare Professional Name		**Signature**			