



**EASTERN  
MENNONITE  
UNIVERSITY**

**HEALTH CENTER**

1306 Park Road  
Harrisonburg VA 22802  
540-432-4317

**NAME** \_\_\_\_\_

**ID NUMBER** \_\_\_\_\_

**DATE OF BIRTH** \_\_\_\_\_

I have been provided a copy of the MMR vaccine information materials and have read, or have had the information explained to me. I have had a chance to ask questions that were answered to my satisfaction. I believe I understand the benefits and risks of the vaccine and ask that the vaccine below be given to me.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

Vaccine	Date Given	Site	Vaccine Manufacturer	Vaccine Lot #	Epiration Date	Initials

\_\_\_\_\_  
Signature of person administering this immunization.

\_\_\_\_\_  
Date