CRAFTON HILLS COLLEGE - HEALTH AND WELLNESS CENTER
MEASLES/MUMPS/RUBELLA QUESTIONNAIRE

1. *Have you had the measles?* *If yes, give date*_____	*Yes*_____	*No*_____
2. *Have you had the Measles/Mumps/Rubella vaccine?* *If yes, give date of injection*_____	*Yes*_____	*No*_____
3. *Are you ill now with something more serious than a cold?* *If yes, explain*_____	*Yes*_____	*No*_____
4. *Have you ever had an allergic reaction to the antibiotic neomycin, gelatin, eggs or a previous MMR vaccine?* *If yes, explain*_____	*Yes*_____	*No*_____
5. *Have you ever had seizures/convulsions or a history of epilepsy?* *If yes, explain*_____	*Yes*_____	*No*_____
6. *Do you have any chronic illnesses/diseases?* *If yes, explain*_____	*Yes*_____	*No*_____
7. *Do you have any blood disorders such as low platelet count or leukemia, or any other condition that lowers the body's resistance to disease such as HIV/AIDS, cancer or lymphomas?* *If yes, explain*_____	*Yes*_____	*No*_____
8. *Are you taking any immunosuppressant drugs, such as cortisone, prednisone, or anticancer medications that would lower the body's resistance to infection?* *If yes, explain*_____	*Yes*_____	*No*_____
9. *Are you receiving cancer treatment such as radiation or chemotherapy?*	*Yes*_____	*No*_____
10. *Have you received a blood transfusion or gamma-globulin injection within the last six months?* *If yes, explain*_____	*Yes*_____	*No*_____
11. *Do you know of <u>any</u> reason (medical, religious, personal) why you should <u>not</u> be immunized?* *If yes, explain*_____	*Yes*_____	*No*_____
12. Additionally, signing this form is verification that you have received the notice of privacy practice for CHC, Health and Wellness Center as required by HIPAA Federal Regulations, the vaccine information sheet (VIS) and the California Immunization Registry Notice (CAIR).		

FEMALES:

1. *What was the first day of your last menstrual period?*_____		
2. *Are you pregnant?*	*Yes*_____	*No*_____
3. *Do you or your parent/guardian know that you should avoid pregnancy for at least three (3) months after the rubella immunization?*	*Yes*_____	*No*_____
4. *I/we understand the above statements and why these questions are necessary.*	*Yes*_____	*No*_____

Please rate the degree to which you agree or disagree with the following statements:

	Strongly Agree	Agree	Disagree	Strongly Disagree
The services provided by the Health & Wellness Center were beneficial to me.				
Being able to access the services provided by the Health & Wellness Center ON Campus provides me with the opportunity to devote more time to my class work.				
It would be a financial hardship for me to obtain the services provided by the Health & Wellness Center OFF Campus.				
If the services provided by the Health & Wellness Center were not available at CHC, I would be able to access the services somewhere else.				

INFORMATION ABOUT PERSON TO RECEIVE VACCINE (Please Print) :

_____
Last Name First Name MI Birthdate Age

_____
Address Telephone Cell Phone

_____
City County State Zip

_____
Signature of Person to receive vaccine or person authorized to make request Date

6/23/2011

FOR CLINIC USE
Crafton Hills College/
Health & Wellness Ctr.

_____
Date Vaccinated

Merck, Sharp & Dohme
Vaccine Manufacturer

_____
Lot Number

_____
Site of Injection

_____
Signature of Adminstr.