2019年交換學生健康檢查說明

同學您好：

依規定您須完成 **本校學生健康檢查** 及 **短期研修健康檢查** **共2項**，檢查時間為2018年2月25日(星期一)上午09：30-13：30，地點於本校教務處3樓（行政大樓東棟），相關說明如下：

一、 本校新生健康檢查：

- 請攜帶 費用 及 本校學生健康資料表 到場受檢。
- 費用：新臺幣**520元**，請於2月25日體檢現場直接繳交報到人員。
- 本校學生健康資料表(詳如附件1)，請貼妥1吋照片1張，並填寫「健康資料表」自填項目資料。
- 本校學生健康資料表中的「身份證號欄位」，請填寫護照號碼，大陸學生請填寫「入臺證號碼」**(範例：10433287932)**

二、 短期研修健康檢查：

- 依臺灣衛生福利部規定自2015年9月1日起，來臺停留3個月以上之大陸港澳地區研修生、外籍生，皆須完成短期研修健康檢查項目表（簡稱丙表，附件2）內含「**麻疹、德國麻疹(風疹)疫苗接種證明或抗體陽性報告**」和「**胸部X光**」兩項健康檢查。
- 若參加本校新生健檢，因體檢項目已包含胸部X光檢查，則無須另作此項檢查，大家只須完成 **麻疹、德國麻疹(風疹)疫苗接種證明** 。

(一)已有麻疹、德國麻疹(風疹)疫苗或有其抗體陽性的接種證明者：

1. 您如果以前曾接種麻疹、德國麻疹(風麻)疫苗，或有其抗體陽性的抽血檢查報告，**請持疫苗證明或抗體報告於體檢現場繳交**。影印證明時 **請務必將包含您的姓名、身份證號等可辨識資料的頁面一併影印，方具有證明效力**(勿只影印接種疫苗填寫日期的頁面，卻無姓名或身份證號，則視同無效證明)。
2. **一定要檢具『兩種』疫苗的接種證明，**若只有一種證明，仍需選擇檢驗抗體（650元）或施打疫苗（500元）。

(二)**沒有麻疹、德國麻疹疫苗接種證明或抗體陽性報告者**：

1. 入臺後參加校內新生體檢，於現場施打疫苗：

   A. 因疫苗數量須提前準備，請要施打疫苗的同學於2018年2月19日中午12時前上網報名 ，網址：http://studaffbh.ccu.edu.tw/files/87-1002-295.php

   (網址路徑：國立中正大學/行政單位/學務處/衛生保健組/報名專區)

   B. 臺灣目前麻疹、德國麻疹(風疹)及腮腺炎疫苗（以下簡稱三合一疫苗），疫苗費用為500元。

C. 施打三合一疫苗者，須填寫**<u>三合一疫苗接種評估單及同意書</u>**(詳如附件 3，中英文版本擇一填寫即可)，請事先填寫列印、簽名完成攜帶至體檢會場繳交，方可施打疫苗。

2. 來臺於新生體檢現場抽血檢查有無麻疹、德國麻疹抗體(不施打麻疹、德國麻疹疫苗)：

A. 需在新生健檢額外付費抽血檢查，麻疹及德國麻疹抽血檢驗費用為新臺幣 650 元。

B. 提醒您若抽血檢查後抗體若呈陰性者，必需自行前往醫院再施打三合一疫苗。

3. 持**<u>麻疹及德國麻疹之抗體陽性檢查報告或預防接種證明</u>**到大陸地區醫療院所施打疫苗或抽血檢驗抗體，由醫院填寫及用印蓋章後將證明現場繳交衛生保健組。

三、體檢費用

健檢項目	費用
新生項目（學生入學健康檢查項目）	520 元
新生+外籍生（丙表：短期研修使用）	1200 元
新生 MMR 抗體檢查	650 元
新生 MMR 疫苗注射	500 元

國立中正大學學生健康資料卡
Chung Cheng University Student Health Examination Form

入學年月 Date of Entry：
_________年(yy) / _____月(mm)

學生基本資料 Contact information

學號 Student No.		姓名 Name		性別 Gender	□男 Male □女 Female
身分證號 Passport No.		系所別 Department		血型 Blood Type	
行動電話 Mobile No.		出生日期 Date of Birth	_____ 年(yy) / ___月(mm) /____日(dd)		1 吋相片黏貼處 Attach photo here
現居地址 Address					

緊急聯絡人、監護人或附近親友 Emergency contact (Parents or guardian)	關係 Relationship	姓名 Name	電話(家) Phone (home)	行動電話 Mobile No.

健康基本資料 Health information

個人疾病史：若有以下特殊疾病尚未痊癒或仍在治療中，請打勾，並可主動提供就診病歷摘要，以作為照護參考。If you are being treated or recovering from any of the following or some other diseases, please inform the medical personnel and also provide your medical records for the healthcare professional's references.

□1. 無 None □7. 癲癇 Epilepsy □13.心理或精神疾病 mental disorder:________________
□2. 肺結核 Tuberculosis □8. 紅斑性狼瘡 SLE (Lupus) □14. 癌症 Cancer:________________
□3. 心臟病 Heart disease □9. 血友病 Hemophilia □15. 海洋性貧血 Thalassemia:________________
□4. 肝炎 Hepatitis □10. 蠶豆症 G6PD deficiency □16. 重大手術名稱 Major surgery:________________
□5. 氣喘 Asthma □11. 關節炎 Arthritis □17. 過敏物質名稱 Allergy to: ________________
□6. 腎臟病 Kidney disease □12. 糖尿病 Diabetes mellitus □18. 其他 Other:________________

□1.領有重大傷病證明卡，類別 Holder of Catastrophic Illness Certificate - Category:________________
□2.領有身心障礙手冊，類別 Holder of Physical/Mental Disability Manual - Category:________________
等級 Level: □極重度 Very serious □重度 Serious □中度 Moderate □輕度 Mild

家族疾病史：患有重大遺傳疾病之家屬稱謂 Family medical history: relative with hereditary disease________________
疾病名稱 Name of disease________________

生活型態 Lifestyle

※ 請勾選最合適的選項 Tick the box that best describes your lifestyle:

1. 過去 7 天內（不含假日），睡眠習慣:How much did you sleep during the past 7 days (*not including weekends, or days off*) ?:
□①每日睡足 7 小時≧7 hours a day □②不足 7 小時<7 hours a day □③時常失眠 I suffer from insomnia
2. 過去 7 天內（不含假日），早餐習慣:How many days did you eat breakfast during the past 7 days (*not including weekends, or days off*)?: □①都不吃 Never□②有時吃 Seldom:____天 days □③每天吃，幾點吃？Every day at (time)?_________點
3. 過去一個月內（不含假日及寒暑假），若以每週至少運動 3 次，每次至少 30 分鐘為基準，心跳達每分鐘 130 下，您做到了嗎：During the past month (*not including weekends, days off, or winter or summer vacation*), have you exercised three times a week, for at least 30 minutes each time, and achieving a heartbeat rate of 130 bpm each time?: □①有 Yes□②沒有 No
4. 過去一個月內，吸菸行為:During the past month, did you smoke?: □①不吸菸 No□②時常吸菸 Often □③每天吸菸，Every day:_____ 支/天 # cigarettes per day □④已戒除 Quit
5. 過去一個月內，喝酒行為: During the past month, did you drink alcohol? □①不喝酒 No□②時常喝酒 Often □③每天喝酒，Every day: ____杯/天 # glasses per day □④已戒除 Quit (1 杯的定義：啤酒 330 ml、葡萄酒 120 ml、烈酒 45 ml。 *Note for ③: please say how many glasses, 'one glass' means: beer 330 ml, wine 120 ml, liquor 45 ml*)
6. 過去一個月內，嚼檳榔：During the past month, did you chew betel quid?□①不嚼檳榔 No□②時常嚼檳榔 Often□③每天嚼檳榔，Every day, ____粒/天# quids per day □④已戒除 Quit
7. 常覺得焦慮、憂鬱嗎？Do you feel worried or depressed？□①沒有 No □②很少 Seldom □③時常 Often
8. 常覺得胸悶嗎？Do you regularly feel chest discomfort? □①沒有 No □②很少 Seldom □③時常 Often
9. 常覺得胃痛嗎？Do you regularly feel stomach discomfort? □①沒有 No □②很少 Seldom □③時常 Often
10. 常覺得頭痛嗎？Do you regularly have headaches? □①沒有 No □②很少 Seldom □③時常 Often
11. 月經情況（女生回答）Menstrual history (*women only*): (1) 初次月經 first period : □①無 No □②有，初經年齡：Age at first period:_________歲 yd (2) 月經週期 Length of menstrual cycle: □①≦20 天 days□②21-40 天 days □③≧41 天 days□④不規律 irregular (差異 7 天以上 *differing in length by more than 7days*) (3) 有無經痛現象？Do you have painful menstrual periods? □①沒有 No□②輕微 Light pain □③嚴重 Severe pain
12. 排便習慣 Bowel habits: 過去 7 天內，多久排便一次？During the past 7 days, how often did you defecate? □①每天至少一次 At least once every day □②2 天 Once in 2 days □③3 天 Once in 3 days □④4 天以上 Once in 4 or more days
13. 網路使用習慣 Internet use: 過去 7 天內(不含假日)每日除了上課及作功課需要之外，累積網路使用的時間？During the past seven days (*not including weekends, or days off*), how many hours did you use the internet every day, apart from when doing homework or in class? □①每天少於 1 小時≦1 hour □②每天約 1-2 小時 1-2 (less than)hours □③每天約 2-4 小時 2-4 (less than) hours □④每天約 4-5 小時 4-5 (less than) hours □⑤每天約 5 小時或以上≧5 hours

自我健康評估 Self -rated Health

1. 過去一個月，一般來說，您認為您目前的健康狀況是 In general, during the past month, would you say your health is
□①極好的 Excellent □②很好 Very good □③好 Good □④普通 Fair□⑤不好 Poor
2. 過去一個月，一般來說，您認為您目前的心理健康是？In general, during the past month, would you say your mental health is□①極好的 Excellent □②很好 Very good □③好 Good □④普通 Fair□⑤不好 Poor

※ 有哪些健康問題？請敘述：Do you currently have any health concerns? Please give details:

自行校外體檢限至
地區級以上醫院

國立中正大學學生健康資料卡
Chung Cheng University Student Health Examination Form

科系 Department		姓名 Name	
學號 Student No.		檢查日期 Date	______ (yy) / ______月(mm) /______日(dd)

身高 Height:________公分 cm　　體重 Weight:________公斤 kg　　腰圍 Waistline:________公分 cm

血壓 Blood Pressure:________/________mmHg　　脈搏 Pulse rate:______次/分 times/min

視力檢查 Vision Test	☐裸視 Uncorrected: 左眼 Left________ 右眼 Right________ ☐矯正視力 Corrected: 左眼 Left________ 右眼 Right________	
眼 Eyes	☐無明顯異常 Normal	☐辨色力異常 Color blindness ☐其他 Other:________
耳鼻喉 ENT	☐無明顯異常 Normal	☐聽力異常 Hearing abnormality: ☐左 Left ☐右 Right ☐疑似中耳炎，如：耳膜破損 Suspected otitis media (*further diagnosis required*), such as from a perforated ear drum ☐扁桃腺腫大 Swollen tonsils ☐耵聹栓塞 Earwax embolism ☐其他 Other:_____
頭頸 Head & Neck	☐無明顯異常 Normal	☐斜頸 Wry neck (torticollis) ☐異常腫塊 Abnormal mass ☐其他 Other:________
胸腔及外觀檢查 Thoracic and visual examination	☐無明顯異常 Normal	☐心肺疾病 Cardiopulmonary disease ☐胸廓異常 Abnormal thorax ☐心律不整 Arrhythmia ☐心雜音 Heart murmur ☐其他 Other:________
腹部 Abdomen	☐無明顯異常 Normal	☐異常腫大 Abnormally swollen ☐其他 Other:________
脊柱四肢 Spine &limbs	☐無明顯異常 Normal	☐脊柱側彎 Scoliosis ☐肢體畸形 Limb deformity ☐蹲踞困難 Difficulty squatting ☐其他 Other:________
皮膚 Skin	☐無明顯異常 Normal	☐癬 Ringworm ☐疥瘡 Scabies ☐疣 Wart ☐異位性皮膚炎 Atopic dermatitis ☐溼疹 Eczema ☐其他 Other:________
Thoracic and visual examination 口腔 Oral	☐無明顯異常 Normal	☐口腔衛生不良 Poor oral hygiene ☐牙結石 Calculus ☐牙齦炎 Gingivitis ☐牙周炎 Periodontitis ☐齒列咬合不正 Dental malocclusion ☐口腔黏膜異常 Abnormal Oral Mucosa ☐其他 Other:________

口腔檢查 Dentition status
代碼 Code：C-齲齒 cavity; X-缺牙 missing; △-已矯治 filled; ψ-阻生牙 impacted tooth; Sp.- 贅生牙 supernumerary tooth

右上 Upper Right	18	17	16	15	14	13	12	11	21	22	23	24	25	26	27	28	左上 Upper left
右下 Lower Right	48	47	46	45	44	43	42	41	31	32	33	34	35	36	37	38	左下 Lower Left

實驗室檢查項目 Laboratory Tests		檢查結果 Result	實驗室檢查項目 Laboratory Tests		檢查結果 Result
尿液檢查 Urinalysis	酸鹼值 PH		血脂肪 Blood lipid	總膽固醇 Total cholesterol (mg/dl)	
	尿蛋白 Protein (＋)(－)			三酸甘油酯 TG(mg/dl)	
	尿糖 Sugar (＋)(－)		腎功能 Renal function	肌酸酐 Creatinine (mg/dl)	
	尿潛血 O.B. (＋)(－)			尿酸(mg/dl)	
血液常規檢查 Blood test	白血球 WBC (10^3/μL)			尿素氮 BUN (mg/dl)	
	紅血球 RBC (10^6/μL)		肝功能 Liver function	麩胺酸草醋酸轉胺酶 SGOT (U/L)	
	血小板 Platelet count (10^3/μL)			麩胺酸丙酮酸轉胺酶 SGPT (U/L)	
	血色素 Hb (g/dl)		B 型肝炎 Hepatitis B	B 型肝炎表面抗原 HBsAg	
	血球容積比 Hct (%)			B 型肝炎表面抗體 Anti-HBs	
	平均血球容積 MCV (fl)		其他 Other	血糖 Blood glucose(mg/dl)	

胸部 X 光檢查 Chest X-ray	檢查結果 Result:☐無明顯異常 No obvious abnormality ☐疑似肺結核病徵 R/O TB ☐肺結核鈣化 TB-related Calcification ☐胸廓異常 Abnormal thorax ☐肋膜腔積水 Pleura cavity edema ☐脊柱側彎 Scoliosis ☐心臟肥大 Cardiomegaly ☐支氣管擴張 Bronchiectasis ☐其他 Other:________	**承辦檢查醫院簽章** **Stamp for hospital where examination was done.**
總評建議 Summary & Sugguestion		

短期研修健康檢查項目表
Health Certificate for Short-Term Students

(醫院名稱、地址、電話、傳真)
(Hospital's Name, Address, Tel, Fax)

檢查日期 / Date of Examination
YYYY / MM / DD

基 本 資 料 / Basic Data

姓 名 Name ：	**性別 Sex** ：☐ **男 / M** ☐ **女 / F**
國　籍 Nationality ：	**護 照 號 碼 Passport No.** ：
出 生 年 月 日 Date of Birth ：YYYY / MM / DD	

實 驗 室 檢 查 / Laboratory Examinations

A. 麻疹及德國麻疹之抗體陽性檢查報告或預防接種證明 / Proof of Positive Measles and Rubella Antibody or Measles and Rubella Vaccination Certificates：

a. 抗體檢查 / Antibody Tests

麻疹抗體 / Measles Antibody ☐ 陽性 / Positive ☐ 陰性 / Negative ☐ 未確定 / Equivocal

德國麻疹抗體 / Rubella Antibody ☐ 陽性 / Positive ☐ 陰性 / Negative ☐ 未確定 / Equivocal

b. 預防接種證明 / Vaccination Certificates (證明文件應註明接種日期、接種院所及疫苗批號。如檢附幼時接種證明，其接種年齡必須大於1歲。/ The certificate should include the date of vaccination, the name of administering hospital or clinic and the batch no. of vaccine. If the childhood vaccination certificate is submitted, it is important to include the record of the vaccines administered only after one year of age.)

☐ 麻疹預防接種證明 / Measles Vaccination Certificate

☐ 德國麻疹預防接種證明 / Rubella Vaccination Certificate

c. ☐ 有接種禁忌，暫不適宜預防接種 / Having contraindications, not suitable for vaccination

B. 胸部 X 光肺結核檢查 / Chest X-ray for Tuberculosis：

X 光發現 / Findings：

判定 / Result：

☐ 合格 / Passed ☐ 疑似肺結核 / TB suspect ☐ 無法確認診斷 / Pending ☐ 不合格 / Failed

☐ 孕婦免驗 / Not required for pregnant women

健康檢查總結果 / The final result of health examination：

☐ 合格 / Passed ☐ 須進一步檢查 / Need further examinations ☐ 不合格 / Failed

負責醫檢師簽章 / Signature of Chief Medical Technologist：

負責醫師簽章 / Signature of Chief Physician：

醫院負責人簽章 / Signature of Superintendent：

日期 / Date：YYYY / MM / DD

備註 / Note：本表為來臺短期研修停留之健康檢查項目表。表單格式僅供參考，學生可分別檢具預防接種證明及胸部 X 光檢查報告。/ This form lists the required medical examination items for students applying for short-term study in Taiwan.This form is only used for reference, students may submit a copy of vaccination certificates and the chest X-ray report instead of completing this form.

本證明三個月內有效。/ The certificate is valid for three months.

麻疹及德國麻疹之抗體陽性檢查報告或預防接種證明(二擇一)
Proof of Positive Measles and Rubella Antibody or Measles and Rubella Vaccination Certificates (alternative)

基 本 資 料 / Basic Data

姓 名 Name ：	性別 Sex ：☐ 男 / M ☐ 女 / F
國 籍 Nationality ：	護 照 號 碼 Passport No. ：
出 生 年 月 日 Date of Birth ：YYYY / MM / DD	

a. 抗體檢查 / Antibody Tests

麻疹抗體 / Measles Antibody ☐ 陽性 / Positive ☐ 陰性 / Negative ☐ 未確定 / Equivocal

德國麻疹抗體 / Rubella Antibody ☐ 陽性 / Positive ☐ 陰性 / Negative ☐ 未確定 / Equivocal

b. 預防接種證明 / Vaccination Certificates (證明文件應註明接種日期、接種院所及疫苗批號。如檢附幼時接種證明，其接種年齡必須大於1歲。/ The certificate should include the date of vaccination, the name of administering hospital or clinic and the batch no. of vaccine. If the childhood vaccination certificate is submitted, it is important to include the record of the vaccines administered only after one year of age.)

☐ 麻疹預防接種證明 / Measles Vaccination Certificate

☐ 德國麻疹預防接種證明 / Rubella Vaccination Certificate

c. ☐ 有接種禁忌，暫不適宜預防接種 / Having contraindications, not suitable for vaccination

負責醫檢師簽章 / Signature of Chief Medical Technologist：

負責醫師簽章 / Signature of Chief Physician：

醫院負責人簽章 / Signature of Superintendent：

日期 / Date of Examination：YYYY / MM / DD

胸部 X 光肺結核檢查報告
Chest X-ray for Tuberculosis Report

基 本 資 料/ Basic Data

姓 名 Name ：	**性別 Sex** ：☐ **男 / M** ☐ **女 / F**
國　籍 Nationality ：	**護 照 號 碼 Passport No.** ：
出 生 年 月 日 Date of Birth ：YYYY / MM / DD	

X 光發現/ Findings：

判定/ Result：

☐ 合格 / Passed ☐ 疑似肺結核 / TB suspect ☐ 無法確認診斷 / Pending ☐ 不合格 / Failed

☐ 孕婦免驗 / Not required for pregnant women

負責醫師簽章/ Signature of Chief Physician：

醫院負責人簽章/ Signature of Superintendent：

日期/ Date of Examination：YYYY / MM / DD

備註/ Note：本證明三個月內有效。/ The certificate is valid for three months.

麻疹、德國麻疹及腮腺炎三合一疫苗接種評估單及同意書

■基本資料

姓名：＿＿＿＿＿＿，學號：＿＿＿＿＿＿＿＿＿＿＿＿，系所：＿＿＿＿＿＿＿＿＿＿＿

出生日期：公元＿＿＿＿＿年＿＿＿月＿＿＿日，聯絡電話：＿＿＿＿＿＿＿＿＿＿＿＿

■健康評估

評　估　內　容	請勾選有或無	
	有	無
1. 以前預防接種後是否有嚴重特殊反應，如發高燒(40.5　℃以上)、抽痙、昏迷、休克…等。		
2. 是否曾對同一類疫苗或對疫苗的任何成分(如雞蛋、明膠及新黴素)有過敏反應。		
3. 是否有嚴重心臟、肝臟、腎臟、白血病、癌症…等病史。		
4. 一年內有否抽痙狀況。		
5. 現在身體有無任何病徵，如發燒（38.5℃以上)、嘔吐、呼吸困難…等或正服用八寶粉、驚風散、水楊酸（阿斯匹靈）等藥物及最近三天內有無就醫、吃藥等情形。		
6. 最近三個月曾否肌肉注射免疫球蛋白(免疫血清)或免疫抑制劑。 最近六個月是否曾輸過血或接受靜脈注射血液製品。 最近十一個月內是否曾靜脈注射高劑量免疫球蛋白。		

■【麻疹－腮腺炎－德國麻疹疫苗MMR】

◎如何注射

用來預防麻疹、腮腺炎、德國麻疹。為活性減毒疫苗，一般成人使用皮下注射一劑，對三種疾病的預防效果可達95%以上，並可獲長期免疫。接種的注意事項：

1. 接種三個月內應避免懷孕。
2. 如曾注射過免疫球蛋白、血漿或輸血，則要等三個月後才能接種，以免失效。

◎何種情況不適合注射

1. 患有嚴重疾病者，但一般感冒仍可接受注射。
2. 免疫不全者，如使用腎上腺皮質素或抗癌藥物者。
3. 懷孕婦女。

◎會產生之副作用

1. 局部反應很少。
2. 與麻疹疫苗一樣在接種後第五至十二天，偶有疹子、咳嗽、鼻炎或發燒。
3. 與德國麻疹疫苗一樣，偶有發燒、暫時性關節痛。
4. 腮腺炎疫苗曾有引起輕微中樞神經反應之病例報告，但機率極小。

同意接種請簽名：＿＿＿＿＿＿＿＿＿（未滿20歲者應由法定代理人或家長簽名）

簽名日期：公元＿＿＿＿＿年＿＿＿＿月＿＿＿＿日

Chung Cheng University Measles, Mumps, Rubella (MMR)

Vaccination Consent Form.

Name：______________________

Student No.：______________________

Dept./Institute/Class：_____________________________________

Date of Birth：___________/________/______________ (DD/MM/YYYY)

1. Do you have any illness or condition that increases their risk of bleeding? Yes☐ No☐
   Please detail____
2. Have you ever had a severe reaction to any medication or vaccine (including anaphylaxis)? Yes ☐No☐
   Please detail____
3. Have you had any serious illness? Yes ☐No☐
   Please detail____
4. Are you currently taking medication? (Include ointments/creams that affect the immune system e.g. Protopic cream) Yes ☐No☐
   Please detail____
5. Have you had any vaccines in the past 3 months? Yes ☐No☐
   Please detail____

Signature：____

(Under age of 20 , please sign by the legal representative)

Date： _________/ _________/_________(DD/MM/YYYY)

MMR Vaccine (Measles, Mumps and Rubella): What you need to know

1. Why get vaccinated?

Measles, mumps, and rubella are serious diseases. Before vaccines they were very common, especially among children.

Measles

- Measles virus causes rash, cough, runny nose, eye irritation, and fever.
- It can lead to ear infection, pneumonia, seizures (jerking and staring), brain damage, and death.

Mumps

- Mumps virus causes fever, headache, muscle pain, loss of appetite, and swollen glands.
- It can lead to deafness, meningitis (infection of the brain and spinal cord covering), painful swelling of the testicles or ovaries, and rarely sterility.

Rubella (German Measles)

- Rubella virus causes rash, arthritis (mostly in women), and mild fever.
- If a woman gets rubella while she is pregnant, she could have a miscarriage or her baby could be born with serious birth defects.

These diseases spread from person to person through the air. You can easily catch them by being around someone who is already infected.

Measles, mumps, and rubella (MMR) vaccine can protect children (and adults) from all three of these diseases.

Thanks to successful vaccination programs these diseases are much less common in the U.S. than they used to be. But if we stopped vaccinating they would return.

2. Who should get MMR vaccine and when?

Children should get 2 doses of MMR vaccine:

- **First Dose**: 12–15 months of age
- **Second Dose**: 4–6 years of age (may be given earlier, if at least 28 days after the 1st dose)

Some infants younger than 12 months should get a dose of MMR if they are traveling out of the country. (This dose will not count toward their routine series.)

Some adults should also get MMR vaccine: Generally, anyone 18 years of age or older who was born after 1956 should get at least one dose of MMR vaccine, unless they can show that they have either been vaccinated or had all three diseases.

MMR vaccine may be given at the same time as other vaccines.

Children between 1 and 12 years of age can get a "combination" vaccine called MMRV, which contains both MMR and varicella (chickenpox) vaccines. There is a separate Vaccine Information Statement for MMRV.

3. Some people should not get MMR vaccine or should wait.

- Anyone who has ever had a life-threatening allergic reaction to the antibiotic neomycin, or any other component of MMR vaccine, should not get the vaccine. Tell your doctor if you have any severe allergies.
- Anyone who had a life-threatening allergic reaction to a previous dose of MMR or MMRV vaccine should not get another dose.
- Some people who are sick at the time the shot is scheduled may be advised to wait until they recover before getting MMR vaccine.
- Pregnant women should not get MMR vaccine. Pregnant women who need the vaccine should wait until after giving birth. Women should avoid getting pregnant for 4 weeks after vaccination with MMR vaccine.

- Tell your doctor if the person getting the vaccine:
  - Has HIV/AIDS, or another disease that affects the immune system
  - Is being treated with drugs that affect the immune system, such as steroids
  - Has any kind of cancer
  - Is being treated for cancer with radiation or drugs
  - Has ever had a low platelet count (a blood disorder)
  - Has gotten another vaccine within the past 4 weeks
  - Has recently had a transfusion or received other blood products

Any of these might be a reason to not get the vaccine, or delay vaccination until later.

4. What are the risks from MMR vaccine?

A vaccine, like any medicine, is capable of causing serious problems, such as severe allergic reactions.

The risk of MMR vaccine causing serious harm, or death, is extremely small.

Getting MMR vaccine is much safer than getting measles, mumps or rubella.

Most people who get MMR vaccine do not have any serious problems with it.

Mild problems

- Fever (up to 1 person out of 6)
- Mild rash (about 1 person out of 20)
- Swelling of glands in the cheeks or neck (about 1 person out of 75)

If these problems occur, it is usually within 6-14 days after the shot. They occur less often after the second dose.

Moderate problems

- Seizure (jerking or staring) caused by fever (about 1 out of 3,000 doses)
- Temporary pain and stiffness in the joints, mostly in teenage or adult women (up to 1 out of 4)
- Temporary low platelet count, which can cause a bleeding disorder (about 1 out of 30,000 doses)

Severe problems (very rare)

- Serious allergic reaction (less than 1 out of a million doses)
- Several other severe problems have been reported after a child gets MMR vaccine, including:
  - Deafness
  - Long-term seizures, coma, or lowered consciousness
  - Permanent brain damage

These are so rare that it is hard to tell whether they are caused by the vaccine.

5. What if there is a serious reaction?
What should I look for?

- Look for anything that concerns you, such as signs of a severe allergic reaction, very high fever, or behavior changes.

  Signs of a severe allergic reaction can include hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, and weakness. These would start a few minutes to a few hours after the vaccination.