JYNNEOS Vaccination Consent Form

Please print clearly

CLIENT INFORMATION			
LEGAL NAME (Last)	(First)	(M.I.)	**SUFFIX** (eg. Jr, III)
PREFERRED NAME (*optional*)	**DATE OF BIRTH** (MM/DD/YYYY)	**AGE**	**PHONE** ( ) ☐ Cell ☐ Home
EMAIL ADDRESS			
ADDRESS	**CITY**	**STATE**	**ZIP**
GENDER ☐ Female ☐ Male ☐ Transgender ☐ Other ☐ Unknown	**Ethnicity:** ☐ Hispanic/Latino ☐ Not Hispanic/Latino ☐ Unknown		
RACE ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander ☐ White ☐ Other			

General Screening	YES	NO	UNK
Have you felt sick, had a fever, or developed a new rash in the last 5 days?			
Have you been diagnosed with the monkeypox virus during the outbreak beginning May 17, 2022?			
Have you ever received a dose of monkeypox or smallpox vaccine? ☐ ACAM2000 ☐ JYNNEOS Date of this vaccination: ____________________ ☐ Date unknown			
Have you ever had an immediate allergic reaction (hives, facial swelling, difficulty breathing, or anaphylaxis) to: ☐ a prior dose or any component of the JYNNEOS vaccine ☐ gentamicin or ciprofloxacin ☐ chicken or egg protein AND currently avoiding all chicken and egg products?			
Are you prone to keloid scarring? (Raised, firm overgrowth of tissue at the site of a healed skin injury.)			
Are you currently pregnant, think you might be pregnant, planning to become pregnant, or breastfeeding?			
Are you moderately or severely immunocompromised due to a medical condition or receipt of immunosuppressive medications or treatments?			
Do you have a history of myocarditis or pericarditis?			
Have you had an mRNA COVID-19 vaccine within the last 4 weeks?			
Eligibility Screening	**YES**	**NO**	**UNK**
Have you had skin-to-skin contact with a person **confirmed by a lab** to have monkeypox within the past 14 days?			
Have you had sex or other skin-to-skin contact at an event or venue linked to monkeypox cases in the past 14 days?			
I attest the patient is eligible under the current guidelines to receive the vaccine dose being requested today.			

CONSENT FOR VACCINATION AND RELEASE OF INFORMATION:

I, the undersigned, give consent as the patient or for the patient listed above to receive the services requested from the Oklahoma City-County Health Department (hereto after "OCCHD") and certify that I am either the patient or that I have legal authority to consent to these services on behalf of the patient.

I authorize disclosure of this information to public health officials, other healthcare professionals, and the Centers for Disease Control and Prevention (CDC). A record of these services will also be entered into OCCHD's Management Information Systems, as necessary. My signature below signifies consent to be contacted by OCCHD, the Oklahoma State Department of Health, and/or the CDC regarding my case.

I understand that record of these services will be recorded in the Oklahoma State Immunization Information System (OSIIS) for the purposes of sharing vaccination information with other healthcare providers and tracking vaccine inventory only. A record of these services will also be entered into OCCHD's Management Information Systems, as necessary.

I acknowledge that I can access a copy of OCCHD's HIPPA Privacy Notice as required by the Health Information Portability and Accountability Act (HIPPA) at https://www.occhd.org/about/contact-us/hippa.

I have read or had explained to me the *Vaccine Information Sheet* (VIS) or *Emergency Use Authorization* (EUA) for the vaccine I am requesting. I have had a chance to ask questions which have been answered to my satisfaction. I believe I understand the benefits and risks of the services I am requesting for the patient. I understand that I, or the patient, may refuse services at any time.

Signature of Patient/Parent/Guardian____Date:_____________________

OFFICE USE ONLY – DO NOT WRITE BELOW

Ask before administration:
Is the patient allergic to any component of the vaccine? ☐ Y ☐ N
Has the client been diagnosed with MPV during the outbreak beginning May 17, 2022 ☐ Y ☐ N

The patient is: ☐ Contact of Confirmed MPX case ☐ Other

Vaccine Details - JYNNEOS	Site:	VIS/EUA given? ☐ Y ☐ N
Mfr: Bavarian Nordic Lot #: ______________________ Exp. Date: ________________ NDC: _50632-0001-01________ Dose (mL): ________________	☐ LT UA SC ☐ RT FA ID ☐ RT UA SC ☐ LT FA ID	VIS/EUA Dated: ________________

Provider Comments:

☐ Client recommended to stay for 15 minutes

☐ Client recommended to stay for 30 minutes

Provider Signature: ____ Date: _______________________________

Vaccine Location: ____