MPOX Vaccination Registration Form

The following questions will help determine if there is any reason we should not give you (or your child) the mpox vaccine. Answering "yes" to any question does not necessarily mean you (or your child) should not be vaccinated. It simply means additional questions must be asked. If a question is unclear, please ask your healthcare provider to help explain.

Patient information

First name | **Last name**

Suffix (optional) | **Date of birth** (MM/DDNYYY) | **Age**

Parent/Guardian first name

Contact information

Mailing address | **City** | **Zip code**

Mobile number | **Email address**

Current Gender Identity

☐ Genderqueer or non-binary ☐ Woman/Female ☐ Man/Male ☐ Trans Female/Trans Woman ☐ Trans Male/Trans Man ☐ Prefer not to say
☐ Identity not listed

Which of the following best represent the patient's sexual orientation?

☐ Bisexual ☐ Gay, lesbian, or same-gender loving ☐ Heterosexual or straight ☐ Questioning, unsure ☐ Prefer not to say
☐ Orientation not listed

What sex is listed on the patient's birth certificate?

☐ Female ☐ Male ☐ Nonbinary or intersex ☐ Prefer not to say

Is the patient Hispanic, Latino, or of Spanish origin?

☐ Yes ☐ No

What is the patient's race or nationality?

☐ American Indian ☐ Asian ☐ Black or African American ☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Prefer not to say
☐ Race not listed

Health insurance

Do you have health insurance? ☐ Yes ☐ No

If yes,

Insurance provider	Primary carrier's full name
Relationship with primary carrier	Policy number

Medical screening questions for the patient

1. Are you sick today?	☐ Yes	☐ No	☐ Don't Know
2. Have you recently been diagnosed with mpox? If yes, when were you diagnosed? ____/ ____/ _____	☐ Yes	☐ No	☐ Don't Know
3. Have you ever received a dose of mpox or smallpox vaccine? If yes, Which vaccine product? ☐ JYNNEOS ☐ ACAM2000 Date of vaccination ____/ ____/ _____	☐ Yes	☐ No	☐ Don't Know
4. Have you had a severe allergic reaction (for example, anaphylaxis) to a prior dose of JYNNEOS?	☐ Yes	☐ No	☐ Don't Know
5. Have you ever had a severe allergic reaction (for example, anaphylaxis) to any medication, vaccine or food? If yes, which medication, vaccine or food? _____	☐ Yes	☐ No	☐ Don't Know
6. Do you have a history of keloid scar formation?	☐ Yes	☐ No	☐ Don't Know
7. Are you pregnant or think you might be pregnant?	☐ Yes	☐ No	☐ Don't Know
8. Are you breastfeeding?	☐ Yes	☐ No	☐ Don't Know
9. Do you have a weakened immune system caused by something such as HIV infection or cancer or take immunosuppressive drugs or therapies?	☐ Yes	☐ No	☐ Don't Know

Information on the risks and benefits of the JYNNEOS vaccine

JYNNEOS vaccine is licensed as a series of two doses administered 28 days apart. The FDA-approved standard regimen is a 0.5mL dose administered subcutaneously. Under an Emergency Use Authorization, an alternative regimen of 0.1 mL administered intradermally may be used for adults aged ≥18 years.

Monkeypox Update: FDA Authorizes Emergency Use of JYNNEOS Vaccine to Increase Vaccine Supply | FDA

- FDA Fact Sheet for JYNNEOS recipients and caregivers: https://www.fda.gov/media/160773/download
- JYNNEOS Vaccine Information Statement: Vaccine Information Statement: Smallpox/Monkeypox Vaccine (JYNNEOS™): What You Need to Know (cdc.gov) – Spanish: https://www.immunize.org/vis/pdf/spanish_smallpox_monkeypox.pdf

Minor consent (needed for children younger than age 12)

I declare that I am (must check one):

- ☐ The parent of the named minor child.
- ☐ The legal guardian of the named minor child.
- ☐ A person with authority to make healthcare decisions on behalf of the named minor child.
    - Describe legal relationship here: _____

I attest to the following

All boxes must be checked in order for the minor younger than age 12 to be vaccinated:

- ☐ I have read and understand the JYNNEOS Emergency Use Authorization (EAU), Fact Sheet and Vaccine Information Statement above and understand the risks and benefits.
- ☐ I GIVE CONSENT for the minor patient to receive the JYNNEOS vaccine. [If you do NOT give consent, do not complete this form.]
- ☐ I understand that by providing my voluntary consent, the minor patient can receive the JYNNEOS vaccine with or without a parent or guardian being physically present at the vaccination appointment.
- ☐ I consent to and authorize all medically necessary treatment in the rare event that the minor patient has a reaction to the vaccine, including but not limited to redness, swelling, tiredness, chills, fever, and other reactions.

Parent/guardian information

Please write your full name

Email address

Mobile number

Address (Street number & name, City, State, Zip code)

CONSENT

- ☐ I understand that all immunizations will be reported to the California Immunization Registry (CAIR2). I understand the information in the patient's CAIR2 record will be shared with the local health department and California Department of Public Health, shall be treated as confidential medical information, and shall be used only as allowed by law. I may refuse to allow the information to be further shared and can request the CAIR2 record be locked by visiting the request to lock my CAIR record web form: **https://cairforms.cairweb.org/SharingRequestForm/SharingRequestForm?SharingType=1&Language=En**
- ☐ I have read, or had explained to me, the Vaccine Information Statement (VIS) about JYNNEOS vaccination. I have had a chance to ask questions, which were answered to my satisfaction, and I understand the benefits and risks of the vaccination as described. I understand that JYNNEOS is a two (2) dose vaccine, given 28-35 days apart, and both doses are required for best vaccine efficacy. I request that the JYNNEOS vaccination be given to me (or the person named above for whom I am authorized to make this request).

Patient or Parent/guardian signature

Date signed (MM/DD/YYYY)

For staff use only

Name _____ **Signature** _____

Date _____ **Time** _____ **Clinic** _____

Product (MPX) _____ **Dose no.** _____ **Dose** (ML) _____ **Asset name** _____

Injection site: RA LA **Asset name:** ID SQ