JYNNEOS MONKEYPOX VACCINE SCREENING AND CONSENT FORM

Administration Facility Name/Facility ID: _____

SECTION 1: INFORMATION ABOUT PATIENT (PLEASE PRINT)

Name: Last:	First:	Middle Initial:		
Date of Birth: Month: Day: Year:	**Mobile Phone Number** (Patient or Guardian)**: ( )**			
Address:	**Apt/Room #:**			
City:	**State:**	**ZIP:**		
Name of Legal Guardian: Last:	First:	Middle Initial:		
Sex (Gender assigned at birth) ☐ Female ☐ Male	**Race** ☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American	☐ Native Hawaiian or Other ☐ Pacific Islander ☐ White	☐ Other Asian ☐ Other Nonwhite ☐ Other Pacific Islander	☐ Unknown
Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Unknown				

Primary Insurance Carrier ID #:_____ Grp #: _____
Insurance Company:_____ Insurance Company Phone #:_____
Insured's Name:_____ Relationship:_____ Insured's Date of Birth:_____
Secondary Insurance Carrier ID #:_____ Grp #: _____
Insurance Company:_____ Insurance Company Phone #:_____
Insured's Name:_____ Relationship:_____ Insured's Date of Birth:_____

Designation of JYNNEOS vaccination dose number? ☐ First Dose ☐ Second Dose

SECTION 2: JYNNEOS SCREENING QUESTIONS

Please check YES or NO for each question.	**Yes**	**No**
1. Have you had a history of a severe allergic reaction (e.g., anaphylaxis) after a previous dose of JYNNEOS? **(CONTRAINDICATION)**		
2. Do you have a history of severe allergic reaction (e.g., anaphylaxis) following gentamicin or ciprofloxacin? (PRECAUTION)		
3. Do you have a history of severe allergic reaction (e.g., anaphylaxis) to chicken or egg protein **AND** are currently avoiding exposure to all chicken or egg products? (PRECAUTION)		
4. Are you currently experiencing moderate or severe acute illness, with or without fever? (PRECAUTION)		
5. Are you under 18 years of age? (You will only be able to receive this vaccination via the subcutaneous route)		
6. Do you have a history of keloid (raised scar after an 'injury' has healed) formation?		

- I certify that I am: (a) the patient and at least 18 years of age; (b) the legal guardian of the patient; or (c) legally authorized to consent for vaccination for the patient named above. Further, I hereby give my consent to the Florida Department of Health (DOH) or its agents to administer the JYNNEOS vaccine.
- I understand that it is not possible to predict all possible side effects or complications associated with receiving vaccine(s). I understand the risks and benefits associated with the above vaccine and have received, read and/or had explained to me the Emergency Use Authorization Fact Sheet on the JYNNEOS vaccine I have elected to receive. I also acknowledge that I have had a chance to ask questions and that such questions were answered to my satisfaction.
- I acknowledge that I have been advised to remain near the vaccination location for approximately 15 minutes (or more in specific cases) after administration for observation. If I experience a severe reaction, I will call 9-1-1 or go to the nearest hospital.
- On behalf of myself, my heirs and personal representatives, I hereby release and hold harmless the State of Florida, the Florida Department of Health (DOH)and their staff, agents, successors, divisions, affiliates, subsidiaries, officers, directors, contractors and employees from any and all liabilities or claims whether known or unknown arising out of, in connection with, or in any way related to the administration of the vaccine listed above.
- I acknowledge that: (a) I understand the purposes/benefits of Florida SHOTS, Florida's immunization information system and (b) DOH will include my personal immunization information in Florida SHOTS and my personal immunization information will be shared with the Centers for Disease Control (CDC) or other federal agencies.
- I further authorize DOH or its agents to submit a claim to my insurance provider or Medicare Part B without supplemental coverage payment for me for the above requested items and services. I assign and request payment of authorized benefits be made on my behalf to DOH or its agents with respect to the above requested items and services. I understand that any payment for which I am financially responsible is due at the time of service or if DOH invoices me after the time of service, upon receipt of such invoice.
- I acknowledge receipt of the DOH Notice of Privacy Practices.

Signature of Patient or Authorized Representative:_____ **Date:** _____

Print Name of Representative and Relationship to Person Receiving Vaccine: _____

Site ()	Route (SC/ID)	Manufacturer (MVX)	Lot # Unit of Use/ Unit of Sale	Expiration Date	Date of EUA Fact Sheet

Administered at location: Facility name/ID	
Administered at location: Type	
Administration Address:	
CVX (product)	
Sending organization:	

Vaccinator Print Name: _____ **Signature:** _____ **Date:** _____

Vaccine Administering Provider Suffix: _____