

New York State Department of Health Bureau of Immunization

## JYNNEOS Vaccine Screening and Consent Form\*

Rec	ipient Name (please print)	Preferred Name						
Add	ress City	State Zip	Email Addre	ess				
Pare	ent/Guardian/ Surrogate (if applicable, please print)	Phone	Preferred La	angua	age			
DOE	Indicate ID Below: TM – Tran Q – Not S	nan/Girl TW – Transg nsgender Man/Boy NB – Non-B ure/Questioning NR – Chose no nder not Listed (write-in) * Gend	ot to Respond	GNC -	– Ge	nde	er Nor	n-Conforming
	Assigned at Birth Key: cate Sex Below: M – Male F – Female I – Intersex NR – Chose not to Respond	Indicate Status Below: W – U – U	Single D – Div Widowed V - Jnknown SI TNER – Life Par	– Civil EPAR	Uni	on		ed y Separated
	nicity <b>Key:</b> DECL – Declined cate Ethnicity Below: HIS – Hispanic Origin NHL – Non-Hispanic Origin UNK – Unknown	Indicate Race Below: BAA - NHP -	Native Americ - African Ameri - Native Hawai – White OTH	ican o	or Bla r Pac	ack cific	DE: Islan	CL – Declined der
Prin	nary Insurance Name	Primary Insurance ID#	Subscriber I	Name	e/DO	В		scriber Relation atient
Prin	nary Insurance Address	Primary Insurance Group #	Primary Inst	uranc	e Ph	one	e #	
Seco	ondary Insurance Name	Secondary Insurance ID#	Subscriber N	Name	e/DC	В		scriber Relation atient
Seco	ondary Insurance Address	Secondary Insurance Group#	Secondary I	nsura	ince	Pho	ne#	
Clin	ic/Office Site Where Vaccine is Administered	Primary Care Physician Addres	ss/Phone Numb	ber				
	Sc	creening Questionnaire						
1.	Have you been diagnosed with the Monkeypox v	irus (MPV) since May 17, 2022?		_ `	Yes		No	□ Unknown
2.	Will you be under the age of 18 on the day of you	r appointment?		_ `	Yes		No	□ Unknown
3.	Are you feeling sick today?			_ `	Yes		No	□ Unknown
4.	Have you ever had an immediate allergic reaction breathing, or anaphylaxis, to any vaccine, injection JYNNEOS vaccine, or do you have a history of development.	n, or antibiotic, or to anycompor	•	_ `	Yes		No	□ Unknown
5.	Have you had a JYNNEOS vaccine in the last 4 weed Date:	eks? If so, when?		_ `	Yes		No	□ Unknown
6.	Have you had a COVID-19 mRNA vaccine (Pfizer o planning on receiving a COVID-19 mRNA vaccine v	-	ks,or are you	_ `	Yes		No	□ Unknown
7.	Are you currently pregnant, planning to become p			_ \	Yes		No	□ Unknown
8.	Are you moderately or severely immunocompron conditions or receipt of immunosuppressive med	nised due to one or more of ther	medical		Yes		No	□ Unknown
9.	Do you have a history of myocarditis (inflammatic (inflammation of the lining around the heart?		ditis	_ `	Yes		No	□ Unknown
10.	Have you read and reviewed the Vaccine Informal Authorization (EUA) for the JYNNEOS vaccine? (JYNNEOS vaccine? (JYNNEOS) www.fda.gov/media/160774/download (https://www.cdc.gov/vaccines/hcp/vis/vis-stater	/NNEOS dated 6/1/22)? or)	ncy Use		Yes		No	□ Unknown

JYNNEOS vaccin  12. If you are 19 or it will be availa	at risk of becoming			ion and is reco		□ Yes	□ No	□ Unknown
12. If you are 19 or it will be availa		-		d the risks and	benefits of the			
it will be availa				tion record to	NIVCIIC vybana	- V	_ NI-	_ U.J
	-	-	immuniza	tion record to	NYSIIS Where	□ Yes	□ No	□ Unknown
roi more imormation reg	arding the current outbro		eading in Ne	w York State, plea	ase visit the NYSDO	l Monkeypo	x Vaccine	 Information
webpage: https://health.ny				, ·		,,		
Consent								
have read, or had expla	ined to me, the Vacc	ine Information Sta	tement (V	IS) about <b>JYNN</b>	IEOS vaccination	ı (if 18 yea	ars or old	ler) or the
mergency Use Authoriz			-	-				·
ttps://www.immunize.d								
onsiderations/jynneos-f					•			-
atisfaction, and I unders iven 28-35 days apart, a								
erson named above for		-					_	-
o process a Medicare or		-	-		-			
				_				
have also been advised vent Reporting System	•	-	-	-	y healthcare pro	ovider or t	o the Va	ccine Adverse
vent keporting system	(VAEKS) at 1-000-022	2-7967 and <u>www.va</u>	iers.iiris.gc	<u> </u>				
understand there will be	e no cost to me for t	his vaccine. I unders	stand that	any monies or	benefits for adr	ninistering	g the vac	cine will be
ssigned and transferred				=			_	
re financially responsibl	e for my medical car	re. I authorize releas	se of any i	nformation ne	eded (including	but not lir	nited to	medical record
opies of claims and item	nized bills) to verify p	ayment and for oth	er public h	nealth purpose	S.			
Recipient/Surrogate,  Telephonic Interpret		re) Date / Time  Date / Time			elationship to I			
OR								
Signature: Interprete	<u>.</u> ?r	Date/ Time		Print: Inte	erpreter's Nam	e and Rel	ationshi	ip to Patient
	<u>.</u> ?r					e and Rel	ationshi	ip to Patient
	Pr	Area Below to b	e Comple	ted by Vaccii	nator		ationshi	ip to Patient
Signature: Interprete		Area Below to b	e Comple	ted by Vaccii	nator eceiving today	?		
Signature: Interprete	Administrat	Area Below to b Which valion Route	e Comple accine is 1	ted by Vaccion the patient re	nator	?		ip to Patient  Sheet Date
Signature: Interprete		Area Below to b	e Comple	ted by Vaccii	nator eceiving today	?		
Vaccine Name JYNNEOS	<b>Administrat</b> □ Subcutaneous	Area Below to b Which voice ion Route  Intradermal	e Comple accine is t I First dose	ted by Vaccinthe patient reconse	nator eceiving today Manufacture	? er & Lot #	† VIS	Sheet Date
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<sup>\*</sup> Use of this form is optional.