New York State Department of Health
Bureau of Immunization

JYNNEOS Vaccine Screening and Consent Form*

Recipient Name (please print)		Preferred Name	
Address	City State Zip		Email Address
Parent/Guardian/ Surrogate (if applicable, please print)		Phone	Preferred Language
DOB	Current Gender ID **Key:** W – Woman/Girl TW – Transgender Woman/Girl M – Man/Boy Indicate ID Below: TM – Transgender Man/Boy NB – Non-Binary Person GNC – Gender Non-Conforming Q – Not Sure/Questioning NR – Chose not to Respond GNL - Gender not Listed (write-in) * Gender Pronouns: write-in by client's name		
Sex Assigned at Birth **Key:** Indicate Sex Below: M – Male F – Female I – Intersex NR – Chose not to Respond		Marital Status **Key:** S – Single D – Divorced M – Married Indicate Status Below: W – Widowed V – Civil Union U – Unknown SEPARATED – Legally Separated PARTNER – Life Partner	
Ethnicity **Key:** DECL – Declined Indicate Ethnicity Below: HIS – Hispanic Origin NHL – Non-Hispanic Origin UNK – Unknown		Race **Key:** AIA – Native American or Alaskan ASN – Asian Indicate Race Below: BAA – African American or Black DECL – Declined NHP – Native Hawaiian or Pacific Islander WHT – White OTH – Other or Multiracial	
Primary Insurance Name	Primary Insurance ID#	Subscriber Name/DOB	Subscriber Relation to Patient
Primary Insurance Address	Primary Insurance Group #	Primary Insurance Phone #	
Secondary Insurance Name	Secondary Insurance ID#	Subscriber Name/DOB	Subscriber Relation to Patient
Secondary Insurance Address	Secondary Insurance Group #	Secondary Insurance Phone #	
Clinic/Office Site Where Vaccine is Administered	Primary Care Physician Address/Phone Number		

Screening Questionnaire

1.	Have you been diagnosed with the Monkeypox virus (MPXV) since May 17, 2022?	□ Yes	□ No	□ Unknown
2.	Will you be under the age of 18 on the day of your appointment?	□ Yes	□ No	□ Unknown
3.	Are you feeling sick today?	□ Yes	□ No	□ Unknown
4.	Have you ever had an immediate allergic reaction, such as hives, facial swelling, difficulty breathing, or anaphylaxis, to any vaccine, injection, or antibiotic, or to any component of the JYNNEOS vaccine, or do you have a history of developing keloid scars?	□ Yes	□ No	□ Unknown
5.	Have you had a JYNNEOS vaccine in the last 4 weeks? If so, when? Date: _____	□ Yes	□ No	□ Unknown
6.	Have you had a COVID-19 mRNA vaccine (Pfizer or Moderna) within the last 4 weeks, or are you planning on receiving a COVID-19 mRNA vaccine within the next 4 weeks?	□ Yes	□ No	□ Unknown
7.	Are you currently pregnant, planning to become pregnant, or breastfeeding?	□ Yes	□ No	□ Unknown
8.	Are you moderately or severely immunocompromised due to one or more of the medical conditions or receipt of immunosuppressive medications or treatments?	□ Yes	□ No	□ Unknown
9.	Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart?	□ Yes	□ No	□ Unknown
10.	Have you read and reviewed the Vaccine Information Statement (VIS) or Emergency Use Authorization (EUA) for the JYNNEOS vaccine? https://www.fda.gov/media/160774/download (or) https://www.cdc.gov/vaccines/hcp/vis/vis-statements/smallpox-monkeypox.pdf	□ Yes	□ No	□ Unknown

11.	**JYNNEOS vaccine is available to help protect against MPXV infection and is recommend for those who are at risk of becoming infected.**** Do you understand the risks and benefits of the JYNNEOS vaccine and consent to receiving the vaccine?	□ Yes	□ No	□ Unknown

****For more information regarding the current outbreak and how MPXV is spreading in New York State, please visit the NYSDOH Monkeypox Vaccine Information webpage: https://health.ny.gov/diseases/communicable/zoonoses/monkeypox/.**

Consent

I have read, or had explained to me, the Vaccine Information Statement (VIS) about **JYNNEOS** vaccination or the Emergency Use Authorization (EUA) fact sheet. These documents are also available in Spanish: https://www.immunize.org/vis/pdf/spanish_smallpox_monkeypox.pdf (and) https://www.cdc.gov/poxvirus/monkeypox/files/interim-considerations/jynneos-factsheet-recipients-caregivers-spanish.pdf. 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). I authorize the release of any medical or other information necessary to process a Medicare or other insurance claim or for other public health purpose. I have received a copy of the Patient Bill of Rights.

I have also been advised that I may report any adverse events that I may experience to my healthcare provider or to the Vaccine Adverse Event Reporting System at 1-800-822-7967 and www.vaers.hhs.gov.

I understand there will be no cost to me for this vaccine. I understand that any monies or benefits for administering the vaccine will be assigned and transferred to the vaccinating provider, including benefits/monies from my health plan, Medicare or other third parties who are financially responsible for my medical care. I authorize release of any information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and for other public health purposes, including reporting to applicable vaccine registries.

Recipient/Surrogate/Guardian (Signature) Date / Time Print Name Relationship to Patient (if other than recipient)

Telephonic Interpreter's ID # Date / Time

OR

Signature: Interpreter Date/ Time Print: Interpreter's Name and Relationship to Patient

□ I have provided the patient (and/or parent, guardian, or surrogate, as applicable) with information about the vaccine and consent to vaccination was obtained.

Vaccinator Signature: _____

	Area Below to be Completed by Vaccinator					
	Which vaccine is the patient receiving today?					
Vaccine Name	**Administration Route**		**Dose**		**Manufacturer & Lot #**	**VIS Sheet Date**
JYNNEOS	□ Subcutaneous	□ Intradermal	□ First dose	□ Second dose		
Administration Site	□ Left triceps area □ Right triceps area □ Volar aspect of forearm (preferred for intradermal) □ Back under the shoulder blade □ Upper chest □ Other _____					
Dosage	□ 0.5 ml □ 0.1 ml					

*** Use of this form is optional.**

September 23 , 2022