JYNNEOS Screening & Vaccination Consent Form

County of Los Angeles Public Health

I. PATIENT INFORMATION

1. Last Name | 2. First Name | 3. M.I.

4. Client's Date of Birth (mm/dd/yyyy) | 5. Telephone Number | International number (if any) | 6. Mother's First Name *Write "Unknown" if not available.*

7. Address *If experiencing homelessness, please enter HOMELESS* | 8. Apt or Unit # | 9. City | 10. State | 11. Zip Code

12. Race | (Other) | 13. Ethnicity | 14. Gender Identity | (Other)

15. Sex at Birth | (Other) | 16. Sexual Orientation | (Other)

17. Are you experiencing Homelessness?

18. Is the place where you sleep a house/apartment, emergency shelter tent/encampment, vehicle, or on the street? Select

Cross Street 1 | *Cross Street 2* | *Other*

19. Parent Name if under 18 years of age (Last Name, First Name):

20. What type of health insurance or medical coverage do you have?

II. MEDICAL SCREENING QUESTIONS - STOP! DO NOT WRITE BELOW THIS LINE

1. Have you previously received a dose of smallpox vaccine (ACAM2000)? *NOTE: Consider vaccination if patient has not received a dose of ACAM2000 within the last 3 years* ○ Yes ○ No
   a. If "YES", when did you receive the vaccine? (MM/DD/YYYY)
2. Are you currently experiencing symptoms of Mpox? (fever, muscle aches, headache, swollen lymph nodes ○ Yes ○ No
3. Have you ever been diagnosed with Mpox? ○ Yes ○ No ○ Don't Know
   a. If "YES", when were you diagnosed? (MM/DD/YYYY)
4. Have you ever had a reaction to JYNNEOS or any component of the vaccine requiring medical attention? ○ Yes ○ No
5. Are you pregnant or breastfeeding? ○ Yes ○ No
6. Are you immunocompromised or have a weakened immune system? ○ Yes ○ No
7. Have you received a Mpox vaccination within the last 24 days (i.e., approximately 3 weeks)? ○ Yes ○ No
   (If YES, patient is not eligible for vaccination since prior dose was received less than 24 days ago)
8. Do you have a history of developing keloid scars? ○ Yes ○ No
   (If YES, only administer 0.5mL subcutaneously)

VERBAL CONSENT:
The patient or legal guardian has been provided the VIS, understands the risks and benefits, and consents to receive the vaccine.
CAIR DISCLAIMER:
The patient understands that all immunizations will be reported to the California Immunization Registry (CAIR2). The patient's CAIR2 record will be shared with the local health department and California Department of Public Health and be treated as confidential medical information, and shall be used only as allowed by law. The patient understands that he/she 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?

JYNNEOS

Manufacturer: Bavarian Nordic A/S
VIS Date: 11/14/2022

LOT #

Expiration Date

Name of the Organization: --- Please select the Organization Name ---

Site Name: ------Enter Site Name----

Date Administered: (MM/DD/YYYY)

Dose Number :

(Verify with the prior dose screening question asked of the client)

Site Administered: Select the site

Dose :

Vaccine Administered by:
First Name | Last Name

Vaccinator's email:

FOR HEALTH DEPARTMENT USE ONLY:

IRIS Incident ID:

CalREDIE ID: *(For LB HD)*

Disease Incident: *(For LAC DPH)* ○

CLEAR FORM