*LHD name*_____
*LHD address*_____

PEF label

DOCUMENT#: _____

HID/LOC/SITE: _____

JYNNEOS VACCINE SCREEN ADMINISTRATION RECORD

NAME: _____ **ID/SOCIAL SECURITY#:** _____

ADDRESS: _____
STREET *CITY* *COUNTY* *STATE* *ZIP*

BIRTHDATE: _____/_____/_____ **PHONE NUMBER:**_____
MONTH *DAY* *YEAR*

RACE: (Check ONE or MORE) ☐ **(W)** White ☐ **(B)** Black or African American ☐ **(N)** American Indian or Alaska Native*****
☐ **(A)** Asian ☐ **(H)** Native Hawaiian or Other Pacific Islander **ETHNICITY:** Hispanic or Latino ☐Yes **or** ☐ No

SEX: (Check ONE) ☐Male ☐Female **How many in HOUSEHOLD:** ___ **Annual INCOME: $**_____ ☐**Income *NOT* Given**

DO YOU HAVE **MEDICAID**? ☐YES***** ☐NO IF YES, **MEDICAID NUMBER**: _____

DO YOU HAVE **MEDICARE**? ☐YES ☐NO IF YES, **MEDICARE NUMBER**: _____

DO YOU HAVE **HEALTH INSURANCE**? ☐YES ☐NO***** IF YES, **COMPANY NAME:** _____
Policy#_____ **Subscriber Name**_____**Group#**_____
YOU or YOUR CHILD ARE LESS THAN 19yrs old AND HAVE HEALTH INSURANCE COVERAGE:

☐ **YES,** the insurance does cover vaccines; ☐ **NO,** the insurance does not cover vaccines *****

I request that payment of authorized medical insurance benefits be made to _____ on my behalf or behalf of my child, for services received. I also authorize the local health department to release medical information to Medicare, Other Third Payors (insurance carriers, Medicaid, etc.) and their agents to determine payment for services. I am aware that should Medicare refuse payment for this service, I will be responsible for the cost. If I am covered by a billable private insurance, I am aware that I may be responsible for some additional charges not covered by my plan.

X_____ **DATE:** _____
Signature of person to receive vaccine or person authorized to make the request (parent or legal guardian/representative)

Screening Questionnaire				
1.	Have you had a **known** exposure to a suspected or confirmed monkeypox case within the past 14 days?	□ Yes	□ No	□ Unknown
2.	Are you at high risk of having had a **potential recent** exposure to monkeypox (within the past 14 days)? This may include intimate, or skin-to-skin contact, with others in areas where monkeypox is spreading. 1. Men who have sex with men, including those who identify as gay, OR bisexual, OR transgender, OR gender non-conforming, OR gender non-binary who are 18 yrs or older **AND** a. Have had multiple or anonymous male, transgender, or gender non-conforming sex partners in the past 14 days; **OR** b. had a diagnosis of gonorrhea and/or early syphilis within the past 12 months; **OR** c. are on HIV pre-exposure prophylaxis (PrEP) **OR** 2. Persons who attended an event/venue where there was a high risk of exposure to an individual(s) with confirmed monkeypox through skin-to-skin or sexual contact in the last 14 days. **OR** 3. Individuals who, on a case-by-case basis, are determined to have reasonable suspicion of recent direct skin-to-skin contact to a known or suspected case of MPX.	□ Yes	□ No	□ Unknown
3.	Do you feel that you may be at risk of **future** exposure to monkeypox, even though you are not at high risk of a recent exposure to monkeypox within the past 14 days?	□ Yes	□ No	□ Unknown
4.	Are you feeling sick today?	□ Yes	□ No	□ Unknown

5.	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? (Gentamycin, Ciprofloxacin, eggs)	□ Yes	□ No	□ Unknown
6.	Have you had a JYNNEOS vaccine in the last 4 weeks? If so, when? Date:	□ 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.	Have you read and reviewed the Vaccine Information Statement (VIS) for the JYNNEOS vaccine? (JYNNEOS dated 6/1/22) https://www.cdc.gov/vaccines/hcp/vis/vis-statements/smallpox-monkeypox.pdf	□ Yes	□ No	□ Unknown
10.	Do you understand the risks and benefits of the JYNNEOS vaccine and consent to receiving the vaccine?	□ Yes	□ No	□ Unknown

CONSENT:
The health department may keep this record in a medical file. They will record what vaccine was given, when the vaccine was given, the name of the company that made the vaccine, the vaccine's special lot number, the vaccine injection site, the signature and title of the person who gave the vaccine, and the address where the vaccine was given.

I have had a chance to ask questions and all were answered to my satisfaction. I understand the benefits/risks of the JYNNEOS vaccine, the JYNNEOS vaccine dosing intervals and attest that I meet all eligibility requirements to receive the requested JYNNEOS vaccine. I give my informed consent for the vaccine be given to me or to the person named above for whom I am authorized to make this request.

Patient Signature X_____
Signature of person to receive vaccine or person authorized to make the request (parent or legal guardian/representative)

FOR HEALTH DEPARTMENT USE ONLY

Vaccine Manufacturer:_____**Vaccine Lot Number:**_____**Injection Site:**_____
Signature and Title of Provider:_____ **Provider# :**_____
NOTES: _____ **ICD Code: Z23.** Encounter for immunization

√	JYNNEOS VACCINE:	√	ADMINISTRATION:
	90611 – JYNNEOS Vaccine – 0.5mL		90471- 1st Dose (18 years & older)
	90611 – JYNNEOS Vaccine – 0.5mL		90471 - 2nd Dose (18 years & older)
	80000 Unspecified Procedure		

□ 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: _____

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