



Maricopa County Department of Public Health Consent for Immunization

Jynneos/Monkey Pox Vaccine Consent Form

First Name: _____ Last Name: _____

Street Address: _____ City: _____ Zip Code: _____ Phone Number: _____

Email: _____ Are you: A Healthcare Worker Lab personnel Other

Race: White Asian Black or African American Hispanic American Indian or Alaska Native Native Hawaiian or Other Pacific Islander
 Other Ethnicity: Hispanic or Latino Not Hispanic or Latino

Gender: _____ Date of Birth: Month _____ Day _____ Year _____ Age: _____

Insured for vaccines? No Yes Name of Insurance: _____ ID# _____

For patients to be vaccinated

The following questions will help us determine if there is any reason, we should not give you Jynneos Vaccine today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

- 1. Do you have a history of severe allergic reaction to any component of the vaccine, including ciprofloxacin, gentamicin or eggs? Yes No
2. Do you have a history of severe allergic reaction to another vaccine or injectable medication? Yes No
3. Are you pregnant or breastfeeding or thinking about becoming pregnant? Yes No N/A
4. Do you have a history of keloid scarring? Yes No
5. Do you have an immunocompromised condition or are you receiving treatment that weakens the immune system? Yes No

I certify that the information provided is true and accurate.

I have been given a copy of the Jynneos Vaccine Information Statement.

Patient/Guardian signature: _____

Printed signature _____ Date _____

Staff Only: Vaccine Administration

ASIS #: _____

Nurse Signature _____ Date _____

Jynneos Site: _____ Route: ID or SQ Dose: 0.1ml or 0.5ml

Jynneos vaccine lot number: _____ Expiration Date: _____ NDC# 50632-001-02