Health, Housing & Human Services
CLACKAMAS COUNTY

Monkeypox (JYNNEOS™) VACCINE ADMINISTRATION RECORD

Clackamas County Public Health
Immunization Program
999 Library Ct., Oregon City, OR 97045
Clinic site: CTC

Patient Name Last: ______________________ First: ______________________ Middle: __________

Preferred Name: ______________________ Pronouns: ______________

Date of Birth: ____________ Age _____ Phone Number: ______________ Language preference: ____________

Email (for follow-up communication): ______________________________________

Questions for Person Receiving Vaccine:	Circle One:		
1. Are you feeling sick today or do you have a fever?	Yes	No	
2. Do you have any swollen lymph nodes?	Yes	No	
3. Do you have a rash, blister or skin lesions?	Yes	No	
4. Are you at least 18 years of age or older?	Yes	No	
5. Have you ever had an immediate allergic reaction of any severity (e.g. hives, facial swelling, difficulty breathing or anaphylaxis) to something that required treatment with epinephrine or EpiPen®, or for which you had to go to the hospital?	Yes	No	Unknown
6. Have you ever had an immediate allergic reaction or anaphylaxis to a previous dose of JYNNEOS™?:	Yes	No	Unknown
7. Have you ever had an immediate allergic reaction or anaphylaxis to any components of the JYNNEOS™ vaccine:			
• Gentamicin, Ciprofloxacin, Benzonase or egg protein?	Yes	No	Unknown
• Have you ever had Stephen-Johnson syndrome (SJS) or Toxic Epidermal Necrolysis (TEN) following either ciprofloxacin or gentamicin?	Yes	No	Unknown
8. Have you ever had an immediate allergic reaction or anaphylaxis to:			
• Another vaccine or injectable medication?	Yes	No	Unknown
• Anything else including: oral medication, food, pet, bee sting, etc.?	Yes	No	Unknown
9. Have you ever fainted from an injection or blood draw?	Yes	No	Unknown
10. 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
11. Do you have a history of myocarditis (inflammation of the heart muscle) or pericarditis (inflammation of the lining around the heart)?	Yes	No	Unknown
12. Are you currently pregnant, planning to become pregnant, or breastfeeding?	Yes	No	N/A
13. Do you have a history of developing keloid scars?	Yes	No	N/A

(next page)

Optional Questions

Gender: ❑ Male ❑ Female ❑ Other ❑ Decline to answer

Patient race: (Check all that apply) ❑ American Indian/Alaskan Native ❑ Asian ❑ Black/ African American

❑ Native Hawaiian/ Pacific Islander ❑ White ❑ Other ❑ Decline to answer

Patient ethnicity: Hispanic? ❑ Yes ❑ No ❑ Unknown

Consent to Vaccination

I have received and read the Smallpox/Monkeypox (JYNNEOS™) Emergency Use Authorization Fact Sheet, and had my questions answered about the vaccine. I understand the risks and benefits involved in receiving this vaccine. I consent to the vaccine being given to me or the person named above for whom I have the legal authority to consent. I consent to the release of any information needed to process insurance claims and/or request payments of medical benefits.

Print name: ______________________________

Signature: ______________________________

Date: ______________________________

If not patient, relationship to patient: ______________________________

FOR CLINIC USE ONLY

INTRADERMAL								
Dose #	Vaccine	Brand Name/Manuf.	Lot Number	Exp.	Dose (mL)	Site/Route	Elig.	Published Dates
	Smallpox/Monkeypox	JYNNEOS			**0.1mL**		S	EUA: 8/9/22 VIS: 8/23/22
SUBCUTANEOUS								
Dose #	Vaccine	Brand Name/Manuf.	Lot Number	Exp.	Dose (mL)	Site/Route	Elig.	Published Dates
	Smallpox/Monkeypox	JYNNEOS			**0.5mL**		S	EUA: 8/9/22 VIS: 8/23/22

Vaccine Administrator Signature: ______________________ Title: ____________ Date: ______________

15 min or 30 min Time to Leave: __________________

Site Codes:
RAID: right arm, intradermal
LAID: left arm, intradermal
LBID: left (upper) back, intradermal
RBID: right (upper) back, intradermal
RASQ: right arm, subcutaneous
LASQ: left arm, subcutaneous
LTSQ: left (lateral) thigh, subcutaneous
RTSQ: right (lateral) thigh, subcutaneous

Alert: ______

VAR: ______