Seattle Infectious Disease Clinic
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Monkeypox Immunization Screening and Consent Form

RECIPIENT INFORMATION

Patient's FIRST name: LAST: M.I.	Sex ❑ M ❑ F ❑ Trans MTF ❑ Trans FTM ❑ Other	Date of Birth (MM/DD/YY)
Street address:	City, State:	Zip Code:
Phone:	Email:	

ETHNICITY

❑ Hispanic ❑ Unknown
❑ Non-Hispanic ❑ Declined

RACE

❑ Native American or Alaskan
❑ Asian
❑ African American or Black
❑ Native Hawaiian or Pacific Islander
❑ White
❑ Other
❑ Declined

INSURANCE INFORMATION

___ **I DO NOT HAVE INSURANCE**

If you have insurance please provide your information. We are able to get reimbursed by insurance companies for administering the vaccine in order to fund our clinic. If you do not have insurance you will still be able to get the vaccine.

Insurance Carrier:		Member ID:
Subscriber's Name:	Birth Date of Subscriber:	Group No:
Patient's Relationship to Subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other		

Have you been prescreened by King County Public Health? YES____ NO____
If you answered YES, please skip the question section and go directly to the consent portion.

The following questions will help us determine if you qualify to receive the vaccine.
If a question is not clear, please ask your healthcare provider to explain it.

	Yes	No
1. Have you had a high-risk exposure to a person with diagnosed monkeypox infection? This includes: sexual contact, kissed with an open mouth, or had significant skin-to-skin or mucous membrane contact.		
2. Are you gay, bisexual, or other man who has sex with men OR transgender persons who has sex with men?		
3. Have you had more than 10 sex partners in the prior 3 months?		
4. Do you have a history of early syphilis or gonorrhea in the prior year?		
5. Have you used methamphetamine in the prior month?		
6. Have you visited a bathhouse, or other public sex venue, or group sex (sex including more than 3 people at the same time) in the prior 3 months?		
7. Are you experiencing homelessness/unstable housing AND currently living in a congregate setting AND had any sex in the prior 3 months?		

CONSENT FOR VACCINATION

I have received, read, and understand the Monkeypox Vaccine Information Sheet (VIS).
I have had the opportunity to ask questions which were answered to my satisfaction.
I understand the benefits and risks of the vaccination as described.
I have responded to the questions above to the best of my ability.

I request that the Monkeypox vaccination be given to me. 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 all information needed (including but not limited to medical records, copies of claims and itemized bills) to verify payment and as needed for other public health purposes, including reporting to applicable vaccine registries.

_____

Reciepient Signature Today's Date Print Name

Area Below to be Completed by Vaccinator				
Which vaccine is the patient receiving today?				Vaccinator Initials _____
Vaccine Name	Administration Site		VIS Date	Lot Number
JYNNEOS	□ Left Deltoid	□ Right Deltoid	6/1/2022	
	□ _____			