Lark Drugs Pharmacy

Mpox JYNNEOS Vaccine Questionnaire

Name: _____ Date: _____

First Name of Parent or Guardian: _____ (Required)

Email: _____ (Optional)

Mobile Number: _____ (Required

☐ By checking this box I certify that I, the person providing patient information, am at least 18 years of age.

☐ Are you feeling sick today?

☐ Have you ever received a dose of the Mpox or smallpox vaccine?

☐ Have you ever had an allergic reaction to JYNNEOS or any component of the vaccine that required medical attention?

☐ Do you have a weakened immune system caused by something such as HIV, cancer, or do you take immunosupressive drugs or therapies?

☐ Are you pregnant or breastfeeding?

☐ Have you been diagnosed with Mpox?

☐ Have you received a COVID-19 vaccine in the last 4 weeks?

☐ Do you have a history of developing Keloid scars?

Patient Risk Group

☐ Occupational risk group (Healthcare worker/ responder or Laboratory worker

☐ Non-occupational risk group at high risk of exposure. (Select all that apply)

- ☐ Attendee of exposure event (e.g. party attended by a case)
- ☐ Person experiencing homelessness
- ☐ STI patient
- ☐ Bathhouse patron
- ☐ Jailed population
- ☐ Other

☐ Verbal Consent: The patient or legal guardian has been provided the benefits and potential adverse reactions, and provides consent to receive the vaccine.

☐ The patient understands that all immunizations will be reported to the California Immunization Registry (CAIR2/RIDE). The information in the patient's immunization record will be shared with the local health department and California Department of Public Health, shall be treated as confidential medical information, and shall be used only as allowed by the law. The patient may refuse to allow the information to be further shared and can request the record be locked by visiting the Request to Lock My CAIR Record web form.

☐ I have read and understand the Mpox Emergency Use Authorization (EUA) Fact Sheet and understand the risk and benefits.