This form can be printed as a paper copy

Smallpox/mpox Immunization Consent Form

HCN: _____

Province/Territory: _____ Expiry: _____

Name: _____

Date of Birth (YYYY/MON/DD): _____ Age: _____

Sex: ☐ M ☐ F ☐ U

Mailing Address: _____ City: _____

Province/Territory: _____ Postal Code: _____

Telephone: (Indicate Preferred)

☐ Home _____ ☐ Cell _____ ☐ Work _____

Email: _____

Which dose of vaccine are you receiving today?

○ First Dose ○ Second Dose

Health Authority or Organization:

☐ Eastern Health
☐ Central Health
☐ Western Health
☐ Labrador-Grenfell Health
☐ Miawpukek First Nation Staff
☐ Nunatsiavut Government Staff
☐ Sheshatshiu Innu First Nation Staff
☐ Mushuau Innu First Nation Staff

Other: _____

Are you a healthcare worker? ○ Yes ○ No

Are you employed within a Regional Health Authority? ○ Yes ○ No

○ Eastern Health ○ Central Health ○ Western Health ○ Labrador-Grenfell Health

If yes, Employee Number: _____

Do you identify as Indigenous? ○ Yes ○ No ○ Do not wish to disclose/identify

☐ LABRADOR INUIT LAND CLAIMS AGREEMENT
☐ MI'KMAQ FIRST NATION ASSEMBLY OF NL
☐ NUNATUKAVUT INUIT
☐ SHESHATSHIU INNU FIRST NATION
☐ MIAWPUKEK FIRST NATION
☐ MUSHUAU INNU FIRST NATION
☐ QALIPU FIRST NATION
INDIGENOUS COMMUNITY-BUT NONE OF THE ABOVE

Have you previously received a smallpox/mpox vaccine? ○ Yes ○ No

If yes, provide dates (if known)_____

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Screening:

Are you feeling ill today?	○ Yes ○ No
Do you have or have you had a mpox infection?	○ Yes ○ No If yes, when were you diagnosed with a MPOX infection?
Are you allergic to eggs or egg products? *Allergic reactions are not a contraindication to immunization with egg protein-containing vaccines. Ask your health care provider who may advise on extra precautions*	○ Yes ○ No If yes, please provide details:
Are you allergic or could you be allergic to tromethamine[1] (trometamol, Tris), benzonase[2], gentamicin[3] or ciprofloxacin[4] which are contained in the vaccine?	○ Yes ○ No ○ Uncertain If yes, please provide details:
Have you had an allergic reaction to another vaccine (another type of smallpox/mpox vaccine or a non-smallpox/mpox vaccine) or other medication given by injection or intravenously in the past?	○ Yes ○ No ○ Uncertain If yes, please provide details:
Do you have any problems with your immune system or are you taking any medications that can affect your immune system (e.g., high dose steroids, chemotherapy, some arthritis medications)? *Ask the health care provider if you are not sure about your medical conditions*	○ Yes ○ No ○ Uncertain If yes, please provide details:
Do you have skin conditions such as atopic dermatitis? *Ask the health care provider if you are not sure about your medical conditions*	○ Yes ○ No ○ Uncertain If yes, please provide details:
Are you or could you be pregnant or are you breastfeeding?	○ Yes ○ No
Have you received another vaccine in the last four weeks, or do you anticipate receiving a vaccine in the next 4 weeks? *To minimize the potential risk of interactions, it is recommended to administer certain types of vaccines 4 weeks before or after administration of IMVAMUNE. Consult your health care provider.*	○ Yes ○ No ○ N/A If yes, please provide details:

1. Tromethamine (trometamol, Tris) may very rarely cause allergic reactions and is found in some medications injected to do tests (contrast media) as well as other medications taken by mouth or injection, and some creams and lotions. Note that this is not a complete list.
2. Benzonase is used for purification of viral vaccines, viral vectors for vaccine, cell and gene therapy, and oncolytic viruses, removing DNA/RNA from proteins and other biologicals; reduction of viscosity caused by nucleic acids; sample preparation in electrophoresis and chromatography and prevention of cell clumping
3. Gentamicin and ciprofloxacin are used as antibiotics in the treatment of some bacterial infections.

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☐ **I have read (or it has been read to me) and I understand the information provided on Smallpox/mpox vaccine. I have had the opportunity to ask questions and to have them answered to my satisfaction. I have had the opportunity to speak with a healthcare worker regarding any special consideration that apply to me in respect to the vaccine for Smallpox/mpox. I consent to the receiving Smallpox/mpox vaccine, including additional Smallpox/mpox vaccine doses that may be recommended.**

Signature: _____ Print name: _____

Date of signature (YYYY/MON/DD): _____

Contraindicated : _____ Reason: _____

Immunizer name/signature: _____

This personal health information is being collected and used under the authority of s. 29 and s.34(a)(m) of the Personal Health Information Act, and will be used for determining eligibility to receive COVID-19 immunization and monitor organizational uptake of the COVID-19 vaccine. If you have concerns about the collection, use or disclosure of your personal health information, please contact the privacy office of your organization.