

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 NL Health Services?

Yes No

Eastern Zone Central Zone

Western Zone Labrador-Grenfell Zone

If yes, Employee Number: _____

Do you identify as Indigenous? Yes No

Do not wish to disclose/identify

LABRADOR INUIT LAND CLAIMS AGREEMENT

MIAWPUKEK FIRST NATION

MI'KMAQ FIRST NATION ASSEMBLY OF NL

MUSHUAU INNU FIRST NATION

NUNATUKAVUT INUIT

QALIPU FIRST NATION

SHESHATSHIU INNU 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?	<input type="radio"/> Yes <input type="radio"/> No
Do you have or have you had a mpox infection?	<input type="radio"/> Yes <input type="radio"/> No If yes, when were you diagnosed with a MPOX infection?
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?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Uncertain
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?	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Uncertain
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)? <i>Ask the health care provider if you are not sure about your medical conditions</i>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Uncertain
Do you have skin conditions such as atopic dermatitis? <i>Ask the health care provider if you are not sure about your medical conditions</i>	<input type="radio"/> Yes <input type="radio"/> No <input type="radio"/> Uncertain
Are you or could you be pregnant or are you breastfeeding?	<input type="radio"/> Yes <input type="radio"/> No

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.

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: _____