# Consent Form For Adults

Version 7.0

## This form should be used to record the administration of MVA-BN (mpox) vaccine for those aged 16 years and older

**Complete the form in block capitals using a pen**
Please complete the details in Parts 1 and 2 and then give the form back to your vaccinator.

## Part 1: Personal Details

**Complete this part for the person getting vaccinated (Please use block capitals)**

Forename: Middle Name:

Surname (Family Name): Otherwise known as:

Personal Public Service Number (PPSN)*:

**This field is not mandatory, the vaccine can be given if PPSN is not provided.*

Date of Birth: D D M M Y Y Y Y

Sex at Birth: Male Female

What is your Gender Identity: Male (including trans male) Female (including trans female)
Non-binary

Mother's Surname at Birth:

Address:

County: Eircode:

Ethnic or Cultural Background:

**A. White**

**A.1** Irish

**A.2** Irish Traveller

**A.3** Roma

**A.4** Any other White background

**B. Black or Black Irish**

**B.1** African

**B.2** Any other Black background

**C. Asian or Asian Irish**

**C.1** Chinese

**C.2** Indian/Pakistani/Bangladeshi

**C.3** Any other Asian background

**D. Other, including mixed background**

**D.1** Arab

**D.2** Mixed, write in description

*Description*

**D.3** Other, write in description

*Description*

**E. Prefer not to say**

Country of Birth:

Mobile Phone Number:

Email Address:

GP Name and Address:

Healthcare Workers Only – What hospital or service do you work in?

## Please answer the following questions

1. Have you ever received a smallpox vaccine? Yes No
   *If yes, what was the name of the smallpox vaccine?*
   *If yes, how many doses of a smallpox vaccine did you receive?* One Dose Two Doses Unknown
   *If yes, what dates did you receive a smallpox vaccine?* Dose 1 D D M M Y Y Y Y
   Dose 2 D D M M Y Y Y Y
2. Have you ever received an MVA-BN (mpox) vaccine? Yes No
   *If yes, what was the name of the MVA-BN (mpox) vaccine?*
   *If yes, how many doses of a MVA-BN (mpox) vaccine did you receive?*
   One Dose Two Doses Unknown
   *If yes, what dates did you receive an MVA-BN (mpox) vaccine?* Dose 1 D D M M Y Y Y Y
   Dose 2 D D M M Y Y Y Y
3. Have you had any allergies to any vaccines in the past? Yes No
4. Have you had any allergies to eggs or egg products (including chicken or feathers) in the past? Yes No
5. Do you have any serious allergies (including Trometamol or antibiotics)? Yes No
   *If yes, please specify*
6. Do you currently have a raised temperature or feel unwell? Yes No
7. Do you have atopic dermatitis? Yes No
8. Do you have a history of keloid scar formation? Yes No
9. Do you have a condition or are you receiving treatment that weakens your immune system? Yes No
10. Do you plan to receive a COVID-19 vaccine in the next 4 weeks? Yes No
11. Have you received an MMR, varicella or yellow fever vaccine in the last 4 weeks? Yes No
12. Do you plan to receive an MMR, varicella or yellow fever vaccine in the next 4 weeks? Yes No
13. Are you pregnant? Yes No
14. Are you breastfeeding? Yes No

**Please Note:** *The MVA-BN (mpox) vaccine may be given to those who are pregnant or breastfeeding after a risk benefit discussion with a healthcare professional. Please speak to your vaccinator if you have any questions about this.*

## Part 2: Consent

**Please Note:** *If you are receiving an MVA-BN (mpox) vaccine called Imvanex, this is licensed by regulators for use in persons aged 12 years and older. If you are receiving an MVA-BN (mpox) vaccine called Jynneos, this is licensed by regulators for use in persons aged 18 years and older. Administration in younger people may be considered following an individual benefit-risk assessment.*

**Please tick the relevant boxes and sign to give consent to be vaccinated with a primary course of MVA-BN (mpox) vaccine OR to receive a MVA-BN (mpox) booster vaccine.**

I have read and understand the accompanying vaccine information, including known side effects.

I consent to receiving a primary course of MVA-BN (mpox) vaccine (1 or 2 doses 28 days apart) as determined by a suitable healthcare professional.

OR

I consent to receiving an MVA-BN (mpox) booster vaccine (1 dose) as determined by a suitable healthcare professional.

Name *(please print)*:

Signature:

Date: D D M M Y Y Y Y

**Privacy Notice:** The HSE do not use consent as a lawful basis for processing personal data. In the interest of transparency, to explain how we collect and use personal information the HSE provides details within the HSE Privacy Notice for Patients and Service Users which is accessible via the HSE Privacy Statement. The processing of your data will be lawful and fair. It will only be processed for specific purposes including, to manage the vaccinations, to report and monitor vaccination programmes, to validate clients and provide health care. Data sharing between HSE departments may also occur.

## For Office Use Only

**Administration Details:**

**Is this person receiving? (please tick)**

Pre Exposure Vaccination ☐ Post Exposure Vaccination ☐

| Dose No. | Date Given (DD/MM/YYYY) | Vaccine Name & Manufacturer | Batch Number | Expiry Date (DD/MM/YYYY) | Use by Date (DD/MM/YYYY) | Injection Site | Injection Route |
|---|---|---|---|---|---|---|---|
| 1 | D D M M Y Y Y Y | | | D D M M Y Y Y Y | D D M M Y Y Y Y | | |
| 2 | D D M M Y Y Y Y | | | D D M M Y Y Y Y | D D M M Y Y Y Y | | |
| Booster dose | D D M M Y Y Y Y | | | D D M M Y Y Y Y | D D M M Y Y Y Y | | |

Prescriber Signature:

PIN/MCRN:

Vaccinator Signature:

PIN/MCRN:

HSE Clinic/Hospital Name, Address, or Stamp: