

Questionnaire for the monkeypox vaccination with the Jynneos® vaccine

| Question | Yes/No |
|---|---|
| Do you have any allergies and/or have you ever had a severe allergic reaction to a vaccine or medication (e.g. allergic shock/anaphylaxis)? | <input type="checkbox"/> No <input type="checkbox"/> If so, please specify: |
| Are you allergic to chicken eggs or egg products? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Are you allergic to any of the following ingredients of Jynneos®: trometamol, sodium chloride, benzonase, gentamicin or ciprofloxacin (antibiotics)? | <input type="checkbox"/> No <input type="checkbox"/> If so, please specify: |
| Are you feverish or otherwise unwell? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Do you currently have a skin rash (which may take the form of bumps, blisters or pimples) or open sores on your body, or do you have monkeypox? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Were you possibly exposed to monkeypox in the past 14 days? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Is your immune system weakened due to illness (e.g. leukaemia, cancer, HIV infection with CD4+ count unknown or < 200 cells/μL), or because of a treatment you are receiving? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you ever had keloid scarring, eczema (atopic dermatitis) or some other skin condition? | <input type="checkbox"/> No <input type="checkbox"/> If so, please specify: |
| Have you ever had an inflammation of the heart muscle (myocarditis) or the membranes containing the heart muscle (pericarditis)? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Are you pregnant, planning a pregnancy, or breastfeeding? | <input type="checkbox"/> No <input type="checkbox"/> Yes |
| Have you previously been vaccinated against smallpox (in Switzerland up to 1972) or monkeypox (Jynneos® or another vaccine)? | <input type="checkbox"/> No <input type="checkbox"/> If so, please give the name of the vaccine and the date of vaccination: |
| Have you had any other vaccinations in the past 4 weeks and/or are any vaccinations planned in the next 4 weeks? | <input type="checkbox"/> No <input type="checkbox"/> If so, please specify: |
| Do you take any medication regularly? | <input type="checkbox"/> No <input type="checkbox"/> If so, please specify: |

If you have answered yes to one or more of the above questions, this is not an exclusion criterion for vaccination. However, an individual assessment is required, as additional precautions may possibly be needed if you have the vaccination. You must therefore discuss these points with the healthcare professional responsible at the vaccination centre.



Declaration of consent for monkeypox vaccination with the Jynneos[®] vaccine (Bavarian Nordic)

This product is not authorised by Swissmedic in Switzerland. It is administered on a no-label use basis.

Last updated: 14.10.2022

Personal details of the person to be vaccinated

Surname

First name

Date of birth (DD.MM.YYYY)

Telephone number

E-mail address

Declaration of consent

Having received a careful and detailed explanation from the healthcare professional responsible, I am fully informed about the Jynneos[®] monkeypox vaccination. I confirm that I have been informed by the responsible healthcare professional that the Jynneos[®] vaccine which I am to receive is not authorised in Switzerland (no-label use). In a personal consultation with the responsible healthcare professional, I have been comprehensively informed about the medical and legal aspects of the use of this vaccine. I have had an opportunity to ask questions, and all my questions have been answered. I have informed the responsible healthcare professional about my medical history.

I confirm that I have been informed in detail about the vaccination with Jynneos[®]. I confirm that I have understood the information on the Jynneos[®] vaccination. I confirm that I have understood the benefits and risks of the Jynneos[®] vaccine. I consent to be vaccinated with the Jynneos[®] vaccine.

Surname and first name

Place

Date (DD.MM.YYYY)

Signature of the person to be vaccinated or the legal representative

If applicable: Details of the legal representative (surname/first name/tel./e-mail)

To be completed by the responsible healthcare professional

Surname and first name of the responsible healthcare professional

Signature of the responsible healthcare professional