Mpox vaccination consent form

Person

Surname _____ First name _____

Date of birth ___/___/_____ (DD/MM/YYYY) Age _____ years NHI _____

Ethnicity (please tick one or more)

☐ NZ European ☐ Māori ☐ Samoan ☐ Cook Island Māori ☐ Tongan ☐ Niuean ☐ Chinese

☐ Indian ☐ Other – please state _____

Consent statements

- ☐ I have read the fact sheet called 'What you need to know about the mpox vaccination'.
- ☐ I know I will need to wait at least 20 minutes after the vaccination.
- ☐ The benefits and risks of the mpox vaccine have been explained to me.
- ☐ The rare and common side effects of the mpox vaccine have been explained to me.
- ☐ I had enough time to ask questions and my questions were answered to my satisfaction.
- ☐ I have received or photographed the fact sheets so I can refer to them after I leave the appointment.
  - 'What you need to know about the mpox vaccination'
  - 'After the mpox vaccination'
- ☐ I was told how and when to seek assistance if I/ the person being vaccinated experience symptoms that may be vaccine related.
- ☐ I agree for this vaccination to be recorded on the Aotearoa Immunisation Register (AIR) and have been provided with AIR privacy information.
- ☐ **I consent to the mpox vaccination being given.**

Signature _____ Date ___/___/_____ (DD/MM/YYYY)

As parent / legal guardian / enduring power of attorney

I _____ am the parent, legal guardian, or enduring power of attorney and agree to the mpox vaccination of the person named above.

Relationship to the person being vaccinated _____ Phone _____

Signature _____ Date ___/___/_____ (DD/MM/YYYY)

Doses requiring prescription

Prescriber (incl. medical practitioner, nurse practitioner or pharmacist prescriber)

I confirm that I have explained the reasons for and the risks and benefits of the mpox vaccination to the person named on this consent form.

Prescriber's name _____ MCNZ/APC number _____

Signature _____ Date ___ / ___ / _____
DD MM YYYY

Vaccination site clinical lead

When administering an off-label dose of vaccine, the clinical lead signs as an informed consent final check with the consumer.

Name _____

Signature _____ Date ___ / ___ / _____
DD MM YYYY

When a prescription is used, the prescriber must retain this form or a copy, and hold securely as a medical record in accordance with local policy.

Vaccination record (for vaccinator use)

Consumer details confirmed ☐ Details entered into AIR ☐

Informed consent checked? ☐ Yes ☐ No Date ___ / ___ / _____
DD MM YYYY

Vaccine details						
Batch	Expiry	Dose	Route	Site	Date	Time
		☐ Dose 1 ☐ Dose 2*	☐ Subcutaneous			

*If administering a second dose, ensure a dose interval of at least 28 days.

Vaccinator information

Place of vaccination _____

_____

Name _____

Signature _____

Observation period

☐ Details of any AEFI or observations recorded

☐ CARM report completed via the CARM website

Signature _____

Departure time _____

For more information about the mpox disease, please visit

info.health.nz/mpox