HB PHARMACY
CARE IS A FAMILY TRADITION
SINCE 1964

VACCINATION INTAKE FORM

Patient Information				
Patient Name:				**Date:**
Patient Address:				
City:	**State:**	**Zip:**	**DOB:**	**Gender:** ☐ Male ☐ Female
Phone #:	**Allergies:**			
Alt Contact:	**Relationship:**			**Phone:**
Weight (select one): ☐ < 130 lbs ☐ 131-152 lbs ☐ 153-200 lbs ☐ 200-259 lbs ☐ > 260 lbs				

HCPC	Product	DX	Dosage	Injection Site	Lot #	Exp.
90658	IIV: _____ ®	Z23	0.5 mL	L / R DELTOID IM		
	Boostrix ®	Z23	0.5 mL	L / R DELTOID IM		
	Shingrix ®	Z23	0.5 mL	L / R DELTOID IM		
	Prevnar ®	Z23	0.5 mL	L / R DELTOID IM		
	Pneumovax ®	Z23	0.5 mL	L / R DELTOID IM		
	Havrix 1440 unit ®	Z23	1 mL	L / R DELTOID IM		

Physician Information		
Ordering Physician: Eric Jackson		**Physician Phone:**
NPI: 1235131251		**Physician Fax:**
Address: 166-18 Ridge Road		
City: North Arlington	**State: NJ**	**Zip: 07031**

Administering Pharmacist		
Name:		
Address: 98 Ridge Road		
City: North Arlington	**State: NJ**	**Zip: 07031**

HB Pharmacy
98 Ridge Rd North Arlington, NJ 07031
phone: (201) 997-2010 | fax: (201) 997-8488

HB Pharmacy Vaccination Consent Form

I have read or had explained to me the Vaccine Information Statementforthe current influenza vaccine and understand the risk and benefit.

I understand that receipt of the vaccine does not completely protect me against the flu or other illnesses that resemble the flu. I further understand that if I have a condition (or am undergoing treatment which causes) or immune-suppression (the reduction in my body's ability to fight infection and illness), the effectiveness of the vaccine in preventing the flu may be diminished.

I GIVE CONSENT to HB Pharmacy and licensed staff fo administer this vaccine to me. I hereby release HB Pharmacy and associated staff from any liability for giving me the influenza vaccination. I agree to defend and hold HB Pharmacy and associated staff harmless from any claim made by any person.

My signature on this form means that all of the information provided to HB Pharmacy is true to the best of my knowledge. If this consent form is not signed, dated and returned I will not be vaccinated.

Patient Signature: _____ Date: _____

Patient Name (Print): _____

☐ I authorize HB Pharmacy to fax a Notification of Vaccination Letter to my Primary Care Provider:

Physician's Name: _____ Fax Number: _____

☐ I do not authorize HB Pharmacy to fax a Notification of Vaccination letter to niy Primary Care Provider.

**If neither box is checked, a Notification of Vaccination Letter will be faxed to my Primary Care Provider, if identified.*

VIS Given: _____ Version Date: _____

HB Pharmacy
98 Ridge Rd North Arlington, NJ 07031
phone: (201) 997-2010 | fax: (201) 997-8488

New Jersey Department of Health
Vaccine Preventable Disease Program
P.O. Box 369, Trenton, NJ 08625-0369
609-826-4860 (Fax 609-826-4866)
www.njiis.nj.gov

NEW JERSEY IMMUNIZATION INFORMATION SYSTEM (NJIIS)
CONSENT TO PARTICIPATE

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -

REGISTRANT INFORMATION	***PARENT/GUARDIAN INFORMATION (if NJIIS Registrant is a minor)***
Registrant Name *(Print)*	Name *(Print)*
Date of Birth	Address
Country of Birth	City, State, Zip Code
Name of Primary Health Care Provider	Relationship to Registrant

I have received information about the New Jersey Immunization Information System (NJIIS) and understand that the purpose of this program is to help remind me when my/my child's immunizations are due and to keep a central record of my/my child's immunization history.

I understand that the medical information in the NJIIS may be shared with authorized health care providers, schools, licensed child care centers, colleges, public health agencies, health insurance companies, and others as permitted by New Jersey Law at N.J.S.A. 26:4-131 et seq. and rules at N.J.A.C. 8:57-3.

I understand that I can get a copy of my/my child's record from my primary health care provider, my local health department, or the New Jersey Department of Health (NJDOH). The NJDOH may be contacted at the website or telephone number listed above.

There is no cost to participate in this program.

☐ Yes, I would like to participate in this program.

☐ No, I do not want to participate in this program.

Signature of Registrant (or Parent/Guardian, IF Registrant under 18 Years of Age)	Date

Name of NJIIS Enrollment Site	Registry ID Number	Medical Record Number

- RETAIN A COPY OF THIS FORM IN THE MEDICAL RECORD -

HB Pharmacy Authoritation Form - Medicare B

Statement to Permit Assignment of Benefits for Inactivated Injectable Influenza Vaccination

It is understood that HB Pharmacy has permission to ask for Medicare payments for medical care, including vaccinations.

It is understood that Medicare needs information about the patient and their medical condition to make a decision about payment. Permission is given for that information to go to Medicare and the companies that handle Medicare payment requests.

It is understood that the Centers for Medicare & Medicaid Services (CMS) is the government's Medicare agency. It is understood that a photocopy of this release is as valid as the original document. Furthermore, it is understood that responsibility for paying any deductible or coinsurance amounts are that ofthe patient's responsible party.

Therefore, it is asked that payment of authorized Medicare benefits be made on the patient's behalf to HB Pharmacy for any services or items furnished to the patient by HB Pharmacy. It is authorized that any holder of medical or other information about the patient release such information to the Centers for Medicare & Medicaid Services (CMS) and its agents as needed to determine these benefits or benefits payable for related services.

Name: _____

Signature: _____ Date: _____

HB Pharmacy
98 Ridge Rd North Arlington, NJ 07031
phone: (201) 997-2010 | fax: (201) 997-8488

Screening Checklist for Contraindications to Vaccines for Adults

PATIENT NAME _____

DATE OF BIRTH ____/____/____
month day year

For patients: The following questions will help us determine which vaccines you may be given today. If you answer "yes" to any question, it does not necessarily mean you should not be vaccinated. It just means we need to ask you more questions. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, food, a vaccine ingredient, or latex?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccine?	☐	☐	☐
4. Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood clotting disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Are you on long-term aspirin therapy?	☐	☐	☐
5. Do you have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
6. Do you have a parent, brother, or sister with an immune system problem?	☐	☐	☐
7. In the past 3 months, have you taken medicines that affect your immune system, such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or have you had radiation treatments?	☐	☐	☐
8. Have you had a seizure or a brain or other nervous system problem?	☐	☐	☐
9. During the past year, have you received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
10. Are you pregnant or is there a chance you could become pregnant during the next month?	☐	☐	☐
11. Have you received any vaccinations in the past 4 weeks?	☐	☐	☐

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Did you bring your immunization record card with you? **yes** ☐ **no** ☐

It is important for you to have a personal record of your vaccinations. If you don't have a personal record, ask your healthcare provider to give you one. Keep this record in a safe place and bring it with you every time you seek medical care. Make sure your healthcare provider records all your vaccinations on it.

Screening Checklist for Contraindications to Vaccines for Children and Teens

PATIENT NAME _____

DATE OF BIRTH ____ / ____ / ____
month day year

For parents/guardians: The following questions will help us determine which vaccines your child may be given today. If you answer "yes" to any question, it does not necessarily mean your child should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Is the child sick today?	☐	☐	☐
2. Does the child have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Has the child had a serious reaction to a vaccine in the past?	☐	☐	☐
4. Does the child have a long-term health problem with lung, heart, kidney or metabolic disease (e.g., diabetes), asthma, a blood disorder, no spleen, complement component deficiency, a cochlear implant, or a spinal fluid leak? Is he/she on long-term aspirin therapy?	☐	☐	☐
5. If the child to be vaccinated is 2 through 4 years of age, has a healthcare provider told you that the child had wheezing or asthma in the past 12 months?	☐	☐	☐
6. If your child is a baby, have you ever been told he or she has had intussusception?	☐	☐	☐
7. Has the child, a sibling, or a parent had a seizure; has the child had brain or other nervous system problems?	☐	☐	☐
8. Does the child have cancer, leukemia, HIV/AIDS, or any other immune system problem?	☐	☐	☐
9. Does the child have a parent, brother, or sister with an immune system problem?	☐	☐	☐
10. In the past 3 months, has the child taken medications that affect the immune system such as prednisone, other steroids, or anticancer drugs; drugs for the treatment of rheumatoid arthritis, Crohn's disease, or psoriasis; or had radiation treatments?	☐	☐	☐
11. In the past year, has the child received a transfusion of blood or blood products, or been given immune (gamma) globulin or an antiviral drug?	☐	☐	☐
12. Is the child/teen pregnant or is there a chance she could become pregnant during the next month?	☐	☐	☐
13. Has the child received vaccinations in the past 4 weeks?	☐	☐	☐

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Did you bring your immunization record card with you? **yes** ☐ **no** ☐

It is important to have a personal record of your child's vaccinations. If you don't have one, ask the child's healthcare provider to give you one with all your child's vaccinations on it. Keep it in a safe place and bring it with you every time you seek medical care for your child. Your child will need this document to enter day care or school, for employment, or for international travel.

immunization action coalition
IAC
immunize.org

Saint Paul, Minnesota • 651-647-9009 • www.immunize.org • www.vaccineinformation.org

www.immunize.org/catg.d/p4060.pdf • Item #P4060 (10/20)

Screening Checklist for Contraindications to Injectable Influenza Vaccination

PATIENT NAME _____

DATE OF BIRTH ____/____/____
month day year

For patients (both children and adults) to be vaccinated: The following questions will help us determine if there is any reason we should not give you or your child inactivated injectable influenza vaccination today. If you answer "yes" to any question, it does not necessarily mean you (or your child) should not be vaccinated. It just means additional questions must be asked. If a question is not clear, please ask your healthcare provider to explain it.

	yes	no	don't know
1. Is the person to be vaccinated sick today?	☐	☐	☐
2. Does the person to be vaccinated have an allergy to an ingredient of the vaccine?	☐	☐	☐
3. Has the person to be vaccinated ever had a serious reaction to influenza vaccine in the past?	☐	☐	☐
4. Has the person to be vaccinated ever had Guillain Barré syndrome?	☐	☐	☐
5. Has the person to be vaccinated ever felt dizzy or faint before, during, or after a shot?	☐	☐	☐
6. Is the person to be vaccinated anxious about getting a shot today?	☐	☐	☐

FORM COMPLETED BY _____ DATE _____

FORM REVIEWED BY _____ DATE _____

Notification of Vaccination Letter Template

Dear doctor or nurse at _____
PATIENT'S PRIMARY CARE CLINIC

We recently provided vaccination services to your patient. We want to make certain that you have information about the vaccines we administered so you can update your patient's medical record. Please contact us if you have any questions about this information.

☐ We provided the patient (or parent/guardian) with a written record of the vaccination(s) given.

☐ We entered information about the vaccine(s) we administered in the regional or state immunization information system.

Patient's name _____ Patient's birthdate _____ (MM/DD/YR)

(For a child, parent/guardian name _____ Parent/guardian birthdate _____ (MM/DD/YR))

The vaccine(s) we administered on _____ DATE is/are checked below.

VACCINES ADMINISTERED

COVID-19

- ☐ mRNA (circle one): Moderna Pfizer
- ☐ viral vector (Janssen [Johnson & Johnson])

Hepatitis B

- ☐ Engerix-B; Recombivax HB; DOSE (circle one): 0.5 mL 1.0 mL
- ☐ Heplisav-B (age 18 yrs and older)
- ☐ PreHevbrio (age 18 yrs and older)

☐ **DTaP** (age 6 yrs and younger)

☐ **DTaP-HepB-IPV** (Pediarix)

☐ **DTaP-IPV** (Kinrix, Quadracel)

☐ **DTaP-IPV/Hib** (Pentacel)

☐ **DTaP-IPV-Hib-HepB** (Vaxelis)

☐ **DT** (through age 6 yrs)

☐ **Tdap** (age 7 yrs and older)

☐ **Td** (age 7 yrs and older)

Hib (monovalent)

- ☐ ActHIB (PRP-T)
- ☐ Hiberix (PRP-T)
- ☐ PedvaxHIB (PRP-OMP)

☐ **Influenza**

BRAND _____

DOSE (mL) _____

ROUTE (circle one): IM Nasal

☐ **IPV** (Polio)

Pneumococcal conjugate (PCV)

- ☐ PCV13, Prevnar 13 (through age 18 yrs)
- ☐ PCV15, Vaxneuvance
- ☐ PCV20, Prevnar 20

☐ **Pneumococcal polysaccharide** (PPSV23) (Pneumovax 23)

Rotavirus

- ☐ RV1 (Rotarix)
- ☐ RV5 (RotaTeq)

☐ **Human papillomavirus** (9vHPV) (Gardasil 9)

☐ **MMR**

☐ **Varicella** (chickenpox) (Varivax)

☐ **MMRV** (ProQuad)

☐ **Hepatitis A** (Havrix; Vaqta) DOSE (circle one): 0.5 mL 1.0 mL

☐ **HepA-HepB** (Twinrix)

☐ **Meningococcal ACWY** (MenACWY) (circle one): (Menactra, MenQuadfi, Menveo)

Meningococcal B (MenB)

- ☐ Bexsero (MenB-4C)
- ☐ Trumenba (MenB-FHbp)

☐ **Zoster** (shingles) (RZV) (Shingrix)

☐ **Other** _____

_____

NAME OF CLINIC PROVIDING SERVICES

CLINIC CONTACT PERSON

ADDRESS

EMAIL ADDRESS

CITY/STATE/ZIP

PHONE

Influenza (Flu) Vaccine (Inactivated or Recombinant): *What you need to know*

Many vaccine information statements are available in Spanish and other languages. See www.immunize.org/vis

Hojas de información sobre vacunas están disponibles en español y en muchos otros idiomas. Visite www.immunize.org/vis

1. Why get vaccinated?

Influenza vaccine can prevent **influenza (flu)**.

Flu is a contagious disease that spreads around the United States every year, usually between October and May. Anyone can get the flu, but it is more dangerous for some people. Infants and young children, people 65 years and older, pregnant people, and people with certain health conditions or a weakened immune system are at greatest risk of flu complications.

Pneumonia, bronchitis, sinus infections, and ear infections are examples of flu-related complications. If you have a medical condition, such as heart disease, cancer, or diabetes, flu can make it worse.

Flu can cause fever and chills, sore throat, muscle aches, fatigue, cough, headache, and runny or stuffy nose. Some people may have vomiting and diarrhea, though this is more common in children than adults.

In an average year, **thousands of people in the United States die from flu**, and many more are hospitalized. Flu vaccine prevents millions of illnesses and flu-related visits to the doctor each year.

2. Influenza vaccines

CDC recommends everyone 6 months and older get vaccinated every flu season. **Children 6 months through 8 years of age** may need 2 doses during a single flu season. **Everyone else** needs only 1 dose each flu season.

It takes about 2 weeks for protection to develop after vaccination.

There are many flu viruses, and they are always changing. Each year a new flu vaccine is made to protect against the influenza viruses believed to be likely to cause disease in the upcoming flu season.

Even when the vaccine doesn't exactly match these viruses, it may still provide some protection.

Influenza vaccine **does not cause flu**.

Influenza vaccine may be given at the same time as other vaccines.

3. Talk with your health care provider

Tell your vaccination provider if the person getting the vaccine:

- Has had an **allergic reaction after a previous dose of influenza vaccine**, or has any **severe, life-threatening allergies**
- Has ever had **Guillain-Barré Syndrome** (also called "GBS")

In some cases, your health care provider may decide to postpone influenza vaccination until a future visit.

Influenza vaccine can be administered at any time during pregnancy. People who are or will be pregnant during influenza season should receive inactivated influenza vaccine.

People with minor illnesses, such as a cold, may be vaccinated. People who are moderately or severely ill should usually wait until they recover before getting influenza vaccine.

Your health care provider can give you more information.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

4. Risks of a vaccine reaction

- Soreness, redness, and swelling where the shot is given, fever, muscle aches, and headache can happen after influenza vaccination.
- There may be a very small increased risk of Guillain-Barré Syndrome (GBS) after inactivated influenza vaccine (the flu shot).

Young children who get the flu shot along with pneumococcal vaccine (PCV13) and/or DTaP vaccine at the same time might be slightly more likely to have a seizure caused by fever. Tell your health care provider if a child who is getting flu vaccine has ever had a seizure.

People sometimes faint after medical procedures, including vaccination. Tell your provider if you feel dizzy or have vision changes or ringing in the ears.

As with any medicine, there is a very remote chance of a vaccine causing a severe allergic reaction, other serious injury, or death.

5. What if there is a serious problem?

An allergic reaction could occur after the vaccinated person leaves the clinic. If you see signs of a severe allergic reaction (hives, swelling of the face and throat, difficulty breathing, a fast heartbeat, dizziness, or weakness), call **9-1-1** and get the person to the nearest hospital.

For other signs that concern you, call your health care provider.

Adverse reactions should be reported to the Vaccine Adverse Event Reporting System (VAERS). Your health care provider will usually file this report, or you can do it yourself. Visit the VAERS website at www.vaers.hhs.gov or call **1-800-822-7967**. *VAERS is only for reporting reactions, and VAERS staff members do not give medical advice.*

6. The National Vaccine Injury Compensation Program

The National Vaccine Injury Compensation Program (VICP) is a federal program that was created to compensate people who may have been injured by certain vaccines. Claims regarding alleged injury or death due to vaccination have a time limit for filing, which may be as short as two years. Visit the VICP website at www.hrsa.gov/vaccinecompensation or call **1-800-338-2382** to learn about the program and about filing a claim.

7. How can I learn more?

- Ask your health care provider.
- Call your local or state health department.
- Visit the website of the Food and Drug Administration (FDA) for vaccine package inserts and additional information at www.fda.gov/vaccines-blood-biologics/vaccines.
- Contact the Centers for Disease Control and Prevention (CDC):
  - Call **1-800-232-4636** (**1-800-CDC-INFO**) or
  - Visit CDC's website at www.cdc.gov/flu.