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

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.

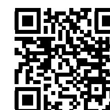
	yes	no	don't know
1. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, food, a vaccine ingredient, or latex?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccine?	☐	☐	☐
4. Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., 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.



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

Vaccine Administration Record for Adults

Patient name: ______________________________

Birthdate: ____________________ Chart number: __________

Clinic name and address

Before administering any vaccines, give the patient copies of all pertinent Vaccine Information Statements (VISs) and make sure he/she understands the risks and benefits of the vaccine(s). Always provide or update the patient's personal record card.

Vaccine	Type of Vaccine[1]	Date given (mo/day/yr)	Funding source (F,S,P)[2]	Route[3] & Site[3]	Vaccine		Vaccine Information Statement (VIS)		Vaccinator[5] (signature or initials & title)
					Lot #	Mfr.	Date on VIS[4]	Date given[4]	
Tetanus, Diphtheria, Pertussis (e.g., Td, Tdap) Give IM.[3]									
Hepatitis A[6] (e.g., HepA, HepA-HepB) Give IM.[3]									
Hepatitis B[6] (e.g., HepB, HepA-HepB) Give IM.[3]									
Human papillomavirus (HPV2, HPV4) Give IM.[3]									
Measles, Mumps, Rubella (MMR) Give SC.[3]									
Varicella (VAR) Give SC.[3]									
Pneumococcal (e.g., PCV13, conjugate; PPSV23, polysaccharide) Give PCV13 IM.[3] Give PPSV23 IM or SC.[3]									
Meningococcal (e.g., MenACWY, conjugate; MPSV4, polysaccharide) Give MenACWY IM.[3] Give MPSV4 SC.[3]									

See page 2 to record influenza, Hib, zoster, and other vaccines (e.g., travel vaccines).

How to Complete This Record

1. Record the generic abbreviation (e.g., Tdap) or the trade name for each vaccine (see table at right).
2. Record the funding source of the vaccine given as either F (federal), S (state), or P (private).
3. Record the route by which the vaccine was given as either intramuscular (IM), subcutaneous (SC), intradermal (ID), intranasal (IN), or oral (PO) and also the site where it was administered as either RA (right arm), LA (left arm), RT (right thigh), or LT (left thigh).
4. Record the publication date of each VIS as well as the date the VIS is given to the patient.
5. To meet the space constraints of this form and federal requirements for documentation, a healthcare setting may want to keep a reference list of vaccinators that includes their initials and titles.
6. For combination vaccines, fill in a row for each antigen in the combination.

Abbreviation	Trade Name and Manufacturer
Tdap	Adacel (sanofi pasteur); Boostrix (GlaxoSmithKline [GSK])
Td	Decavac (sanofi pasteur); generic Td (MA Biological Labs)
HepA	Havrix (GSK); Vaqta (Merck)
HepB	Engerix-B (GSK); Recombivax HB (Merck)
HepA-HepB	Twinrix (GSK)
HPV2	Cervarix (GSK)
HPV4	Gardasil (Merck)
MMR	MMRII (Merck)
VAR	Varivax (Merck)
PCV13, PPSV23	Prevnar 13 (Pfizer); Pneumovax 23 (Merck)
MenACWY	Menactra (sanofi pasteur); Menveo (Novartis)
MPSV4	Menomune (sanofi pasteur)

Pneumococcal Conjugate Vaccine: *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?

Pneumococcal conjugate vaccine can prevent **pneumococcal disease**.

Pneumococcal disease refers to any illness caused by pneumococcal bacteria. These bacteria can cause many types of illnesses, including pneumonia, which is an infection of the lungs. Pneumococcal bacteria are one of the most common causes of pneumonia.

Besides pneumonia, pneumococcal bacteria can also cause:

- Ear infections
- Sinus infections
- Meningitis (infection of the tissue covering the brain and spinal cord)
- Bacteremia (infection of the blood)

Anyone can get pneumococcal disease, but children under 2 years old, people with certain medical conditions or other risk factors, and adults 65 years or older are at the highest risk.

Most pneumococcal infections are mild. However, some can result in long-term problems, such as brain damage or hearing loss. Meningitis, bacteremia, and pneumonia caused by pneumococcal disease can be fatal.

2. Pneumococcal conjugate vaccine

Pneumococcal conjugate vaccine helps protect against bacteria that cause pneumococcal disease. There are three pneumococcal conjugate vaccines (PCV13, PCV15, and PCV20). The different vaccines are recommended for different people based on age and medical status. Your health care provider can help you determine which type of pneumococcal conjugate vaccine, and how many doses, you should receive.

Infants and young children usually need 4 doses of pneumococcal conjugate vaccine. These doses are recommended at 2, 4, 6, and 12–15 months of age.

Older children and adolescents might need pneumococcal conjugate vaccine depending on their age and medical conditions or other risk factors if they did not receive the recommended doses as infants or young children.

Adults 19 through 64 years old with certain medical conditions or other risk factors who have not already received pneumococcal conjugate vaccine should receive pneumococcal conjugate vaccine.

Adults 65 years or older who have not previously received pneumococcal conjugate vaccine should receive pneumococcal conjugate vaccine.

Some people with certain medical conditions are also recommended to receive pneumococcal polysaccharide vaccine (a different type of pneumococcal vaccine, known as PPSV23). Some adults who have previously received a pneumococcal conjugate vaccine may be recommended to receive another pneumococcal conjugate vaccine.

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

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 any type of pneumococcal conjugate vaccine (PCV13, PCV15, PCV20, or an earlier pneumococcal conjugate vaccine known as PCV7), or to any vaccine containing diphtheria toxoid** (for example, DTaP), or has any **severe, life-threatening allergies**

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

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

Your health care provider can give you more information.

4. Risks of a vaccine reaction

- Redness, swelling, pain, or tenderness where the shot is given, and fever, loss of appetite, fussiness (irritability), feeling tired, headache, muscle aches, joint pain, and chills can happen after pneumococcal conjugate vaccination.

Young children may be at increased risk for seizures caused by fever after a pneumococcal conjugate vaccine if it is administered at the same time as inactivated influenza vaccine. Ask your health care provider for more information.

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/vaccines**.