HB Pharmacy

Vaccination Intake Sheet

Patient Information				
Patient Name:				Date:
Patient Address:				
City:	State:	Zip:	DOB:	Gender: M / F
Phone #:		Allergies:		
Alerternate Contact:		Relationship:		Phone:
Weight (circle one):	< 130 lbs	131 - 152 lbs	153 - 200 l	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:	
Physician Address: 16-18 Ridge Road		
City: North Arlington	State: NJ	Zip: O7031

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

HB Pharmacy Vaccination Consent Form

I have read or had explained to me the Vaccine Information Statement for the 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 to 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 my 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: _____

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 -

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 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. Are you sick today?	☐	☐	☐
2. Do you have allergies to medications, food, a vaccine component, or latex?	☐	☐	☐
3. Have you ever had a serious reaction after receiving a vaccination?	☐	☐	☐
4. Do you have a long-term health problem with heart, lung, kidney, or metabolic disease (e.g., diabetes), asthma, a blood 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 medications 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. For women: 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.

immunization action coalition
immunize.org

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

www.immunize.org/catg.d/p4065.pdf · Item #P4065 (10/20)

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.

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

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

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

☐ DTaP (age 6 yrs and younger)

☐ DTaP-HepB-IPV (Pediarix)

☐ DTaP-IPV (Kinrix, Quadracel)

☐ DTaP-IPV/Hib (Pentacel)

☐ DT (through age 6 yrs)

☐ Tdap (age 7 yrs and older)

☐ Td (age 7 yrs and older)

Hib (monovalent)
- ☐ ActHIB
- ☐ Hiberix
- ☐ PedvaxHIB

☐ IPV (Polio)

☐ Pneumococcal conjugate (PCV) (Prevnar 13)

☐ Pneumococcal polysaccharide (PPSV) (Pneumovax 23)

Rotavirus
- ☐ RV1 (Rotarix)
- ☐ RV5 (RotaTeq)

☐ Human papillomavirus (HPV) (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 (Menactra, Menveo)

Meningococcal B
- ☐ Bexsero
- ☐ Trumenba

☐ Influenza
- BRAND _____
- DOSE (mL) _____
- ROUTE (circle one): IM ID NAS

Zoster (shingles)
- ☐ RZV (Shingrix, recombinant)
- ☐ ZVL (Zostavax, live)

☐ Other _____

HB Pharmacy
NAME OF CLINIC PROVIDING SERVICES

98 Ridge Road
ADDRESS

North Arlington, NJ 07031
CITY/STATE/ZIP

John C. Belitti, RPh
CLINIC CONTACT PERSON

pharmacist@hbpharmacy.com
EMAIL ADDRESS

201-997-2010
PHONE

Technical content reviewed by the Centers for Disease Control and Prevention

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

www.immunize.org/catg.d/p3060.pdf • Item #P3060 (5/18)

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)

Technical content reviewed by the Centers for Disease Control and Prevention

For additional copies, visit www.immunize.org/catg.d/p2023.pdf • Item #P2023 (4/14)

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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]	
Influenza (e.g., IIV3, trivalent inactivated; IIV4, quadrivalent inactivated; RIV, recombinant inactivated; LAIV4, quadrivalent live attenuated) Give IIV and RIV IM.[3] Give LAIV IN.[3]									
Hib Give IM.[3]									
Zoster (Zos) Give SC.[3]									
Other									

See page 1 to record Tdap/Td, hepatitis A, hepatitis B, HPV, MMR, varicella, pneumococcal, and meningococcal 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.

Abbreviation	Trade Name and Manufacturer
LAIV (Live attenuated influenza vaccine)	FluMist (MedImmune)
IIV (Inactivated influenza vaccine), RIV (recombinant influenza vaccine)	Afluria (CSL Biotherapies); Agriflu (Novartis); Fluarix (GSK); Flublok (Protein Sciences Corp.); Flucelvax (Novartis); FluLaval (GSK); Fluvirin (Novartis); Fluzone, Fluzone Intradermal, Fluzone High-Dose (sanofi pasteur)
Hib	ActHIB (sanofi pasteur); Hiberix (GSK); PedvaxHib (Merck)
ZOS (shingles)	Zostavax (Merck)

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Recombinant Zoster (Shingles) Vaccine: *What You Need to Know*

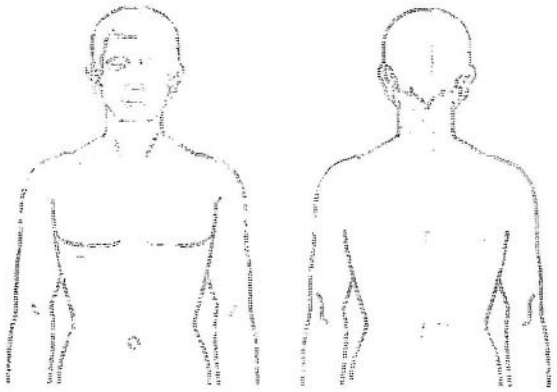
Many vaccine information statements are available in Spanish and other languages. See www.immunize.org/vis

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

1. Why get vaccinated?

Recombinant zoster (shingles) vaccine can prevent **shingles**.

Shingles (also called herpes zoster, or just zoster) is a painful skin rash, usually with blisters. In addition to the rash, shingles can cause fever, headache, chills, or upset stomach. Rarely, shingles can lead to complications such as pneumonia, hearing problems, blindness, brain inflammation (encephalitis), or death.



The risk of shingles increases with age. The most common complication of shingles is long-term nerve pain called postherpetic neuralgia (PHN). PHN occurs in the areas where the shingles rash was and can last for months or years after the rash goes away. The pain from PHN can be severe and debilitating.

The risk of PHN increases with age. An older adult with shingles is more likely to develop PHN and have longer lasting and more severe pain than a younger person.

People with weakened immune systems also have a higher risk of getting shingles and complications from the disease.

Shingles is caused by varicella-zoster virus, the same virus that causes chickenpox. After you have chickenpox, the virus stays in your body and can cause shingles later in life. Shingles cannot be passed from one person to another, but the virus that causes shingles can spread and cause chickenpox in someone who has never had chickenpox or has never received chickenpox vaccine.

2. Recombinant shingles vaccine

Recombinant shingles vaccine provides strong protection against shingles. By preventing shingles, recombinant shingles vaccine also protects against PHN and other complications.

Recombinant shingles vaccine is recommended for:

- **Adults 50 years and older**
- **Adults 19 years and older who have a weakened immune system** because of disease or treatments

Shingles vaccine is given as a two-dose series. For most people, the second dose should be given 2 to 6 months after the first dose. Some people who have or will have a weakened immune system can get the second dose 1 to 2 months after the first dose. Ask your health care provider for guidance.

People who have had shingles in the past and people who have received varicella (chickenpox) vaccine are recommended to get recombinant shingles vaccine. The vaccine is also recommended for people who have already gotten another type of shingles vaccine, the live shingles vaccine. There is no live virus in recombinant shingles vaccine.

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

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 recombinant shingles vaccine**, or has any **severe, life-threatening allergies**
- Is **currently experiencing an episode of shingles**
- Is **pregnant**

In some cases, your health care provider may decide to postpone shingles 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 before getting recombinant shingles vaccine.

Your health care provider can give you more information.

4. Risks of a vaccine reaction

- A sore arm with mild or moderate pain is very common after recombinant shingles vaccine. Redness and swelling can also happen at the site of the injection.
- Tiredness, muscle pain, headache, shivering, fever, stomach pain, and nausea are common after recombinant shingles vaccine.

These side effects may temporarily prevent a vaccinated person from doing regular activities. Symptoms usually go away on their own in 2 to 3 days. You should still get the second dose of recombinant shingles vaccine even if you had one of these reactions after the first dose.

Guillain-Barré syndrome (GBS), a serious nervous system disorder, has been reported very rarely after recombinant zoster vaccine.

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. 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**.