

# Generation Station Newsletter

September, 2023



## Updates & Coming Events

As we leave summer behind we wanted to bring some important issues to mind.

### Holiday Closing

Labor Day – September 4

Thanksgiving – Nov 23-24



Christmas Break - December 22- January 2, 2024



### Postponed 5-Day Opening

We were hoping to re-open Generation Station 5 days per week beginning the week after Labor Day. Unfortunately, we have not had enough interest to be able to do so. Therefore, Friday opening has been postponed until further notice. If you are interested in attending on Friday please let us know right away. Thank you!

### Flu/Covid/Pneumonia Shot Clinic



Our early Vaccination Clinic will be held on Thursday, September 28, 2023. For anyone wishing to receive of the vaccines listed above, please fill out attached form in advance and return via email or drop off at our office. Our Pharmacist of Record, Dr. Moby Abraham from our local Savon Pharmacy will be administering the vaccinations. We strongly suggest receiving the flu and the new Covid Vaccination which will cover the old and new varriants. If the vaccine has not arrived by the time of the clinic, we will do a second clinic for Covid.



## Informed Consent for Immunization with Inactivated &amp; Live Vaccines

Last Name		First Name		Middle	Date of Birth	Age	Sex Assigned at Birth <input type="checkbox"/> M <input type="checkbox"/> F
Home Address		City	State	Zip	Phone #	<input type="checkbox"/> Home <input type="checkbox"/> Cell	
Vaccine(s) requested: <input type="checkbox"/> Flu <input type="checkbox"/> COVID-19 <input type="checkbox"/> Pneumonia <input type="checkbox"/> Shingles <input type="checkbox"/> Hepatitis B <input type="checkbox"/> Tetanus/Whooping Cough <input type="checkbox"/> Other(s): _____		Ethnicity: <input type="checkbox"/> Hispanic or Latino <input type="checkbox"/> Non-Hispanic or Latino <input type="checkbox"/> Decline to State (Unknown)		If less than 66 pounds list weight: _____ Lbs.	Which arm do you prefer for vaccine? <input type="checkbox"/> Left <input type="checkbox"/> Right Email address: _____ Medicare patients only: Last 4 digits of SSN: _____ Medicare Part B ID#: _____ Primary Care Provider Name: _____ Phone: _____ Address: _____		
Race: <input type="checkbox"/> Asian <input type="checkbox"/> American Indian		<input type="checkbox"/> Pacific Islander		<input type="checkbox"/> Black or African American		<input type="checkbox"/> Caucasian <input type="checkbox"/> Two or More <input type="checkbox"/> Other	

Screening Questions		Yes	No
1. Are you sick today?		<input type="checkbox"/>	<input type="checkbox"/>
2. Do you have any allergies to medications, food or vaccines? If yes, please list: _____		<input type="checkbox"/>	<input type="checkbox"/>
3. Have you ever had a serious reaction or fainted after receiving a vaccination (e.g. Guillain-Barré Syndrome)?		<input type="checkbox"/>	<input type="checkbox"/>
4. For women: Are you pregnant or are you considering becoming pregnant in the next month?		<input type="checkbox"/>	<input type="checkbox"/>
5. Check all that apply to you: <input type="checkbox"/> Asthma or lung disease <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Tobacco Smoker <input type="checkbox"/> Seizure disorder or a brain disorder (tdap only) <input type="checkbox"/> Have medical condition(s) or take medication(s) that weaken your immune system? (e.g. cancer, leukemia, HIV, active shingles, oral steroids, anticancer or antiviral drugs)		<input type="checkbox"/>	<input type="checkbox"/>
6. Please indicate which vaccine(s) you would like more information about? <input type="checkbox"/> Hepatitis A <input type="checkbox"/> MMR (Measles, Mumps, Rubella) <input type="checkbox"/> Travel Vaccines <input type="checkbox"/> Childhood Vaccines <input type="checkbox"/> Other: _____ <input type="checkbox"/> Unsure: would like an assessment done of potential vaccination gaps or needs		<input type="checkbox"/>	<input type="checkbox"/>
Immunization Needs		Yes	No
7. Have you ever received a PNEUMONIA vaccine? If yes, when and what kind(s)? _____		<input type="checkbox"/>	<input type="checkbox"/>
8. Patients 50 and older <u>or</u> immunocompromised: Have you ever received the SHINGLES vaccine? If so, what date(s): _____		<input type="checkbox"/>	<input type="checkbox"/>
9. Patients 19 to 59 years old: Have you received a hepatitis B vaccine series?		<input type="checkbox"/>	<input type="checkbox"/>
10. Patients under 46: Have you received the HPV (Human Papillomavirus) vaccine?		<input type="checkbox"/>	<input type="checkbox"/>
11. Patients aged 11 to 23: Have you received a meningitis vaccine?		<input type="checkbox"/>	<input type="checkbox"/>
12. How many years has it been since your last TETANUS vaccine? _____ years		<input type="checkbox"/>	<input type="checkbox"/>
LIVE VACCINES ONLY (chickenpox, cholera, rotavirus, flu, MMR, ILI, rotavirus, oral typhoid, and yellow fever)		Yes	No
13. Have you received any vaccination in the past 4 weeks? If yes, please list: _____		<input type="checkbox"/>	<input type="checkbox"/>
14. During the past year, have you received a blood transfusion, blood products, been given a medicine called immune (gamma) globulin, or had radiation therapy?		<input type="checkbox"/>	<input type="checkbox"/>
15. Have you had your thymus gland removed or problems with your thymus such as myasthenia gravis, DiGeorge syndrome, or thymoma? (yellow fever only)		<input type="checkbox"/>	<input type="checkbox"/>
16. Are you currently taking any antibiotics or antimalarial medications? (oral typhoid only)		<input type="checkbox"/>	<input type="checkbox"/>
17. Do you have a history of thrombocytopenia or thrombocytopenia purpura? (MMR* II only)		<input type="checkbox"/>	<input type="checkbox"/>
18. For age under 18: Are you taking aspirin or an aspirin containing medication? (Intranasal flu only)		<input type="checkbox"/>	<input type="checkbox"/>

## Informed Consent: Please read and sign.

By my signature below, I consent to the administration of the vaccine(s) by a pharmacist or a supervised student pharmacist or technician, or other authorized person, where permitted by law or state/federal guidance, employed or contracted by Albertsons Companies or one of its affiliated pharmacies and to be contacted at the number provided above regarding other immunizations for which I am due or eligible to receive. The above information is true and correct. I attest I meet eligibility criteria for the vaccination (if any); if I am the parent/guardian of the minor patient, I attest the minor patient meets eligibility criteria for the vaccination. I also release Albertsons Companies and its subsidiaries, affiliates, officers, directors, employees, and agents from all liability, including acts of omission or commission, resulting, or arising from my receipt of this vaccination. I understand I am receiving a flu vaccination and it is prior to September 1<sup>st</sup>. I am either a parent signing on behalf of my child receiving the vaccine, pregnant in my third trimester, or I am unable to return at a later date. 2) I authorize Albertsons Companies to submit a claim for reimbursement on my behalf to Medicare or any other contracted third-party payer, including my employer if they are paying directly for my vaccination; if the claim is denied, I understand I will be responsible for payment; 3) I am of legal age and authorized to execute this consent form or I am the parent/guardian of the minor patient. 4) I will immediately alert the pharmacist of any medical condition or effectiveness of the vaccine. 5) I have been counseled about potential side effects after vaccination, when they may occur, and when and where I should seek treatment. I am responsible for following up with my physician at my expense if I experience any side effects. 6) I should remain in the area for observation for 15 minutes unless I have a history of an immediate allergic reaction of any severity to a vaccine or injectable vaccine. 7) I have read, or have had read to me, the Vaccine Information Statement(s) ("VIS") or Emergency Use Authorization ("EUA") provided for the vaccine(s) to be administered. I have had the opportunity to ask questions, and all my questions have been answered to my satisfaction. I understand the benefits and risks of the vaccine(s). 8) I have been offered and/or provided a copy of the company's Notice of Privacy Practices in compliance with the Health Insurance Portability and Accountability Act (HIPAA). 9) This vaccination, including any vaccination granted additional privacy protections under state or federal law, is subject to reporting by my pharmacy or its business associate to an immunization registry, which may share my immunization data with others, and to my primary care physician, the authorizing physician, or the local Department of Health, if applicable, and I authorize \_\_\_\_\_ reporting of my receipt of this vaccination to my primary care provider. I understand that failure to check authorize/do not authorize will serve as authorization. (South Dakota, Maine, Massachusetts, and New Hampshire only: I understand I have the right to object to the sharing of my data to the above-mentioned parties through such registries.) For minor's parent or guardian, below consent confirms receipt of written notice to visit a pediatrician annually.

X

Signature of Patient or Parent/Guardian of Minor Patient (put relationship to minor)

Printed Name

Date

Below for Pharmacy Use Only:

WA ONLY: Substitution Permitted:

Dispense as Written:

Vaccine Name	Lot #	Expiration Date	Manufacturer	Dose (ml)	Dose #	Route	Site (circle)	VIS/EUA Pub. Date
COVID-19( )					#	IM	R / L Deltoid	
Flu ( )						IM	R / L Deltoid	
Shingrix®			GSK	0.5	<input type="checkbox"/> 1 <input type="checkbox"/> 2	IM	R / L Deltoid	2/4/2022
Prevnar 20®			Pfizer	0.5	1	IM	R / L Deltoid	
							R / L	
							R / L	

Ordering RPh Signature:

Name of Administrator:

Admin/VIS Provided Date: ☐ NPP Offered

Counseling (Please circle): Accepted / Declined

RxBIN: \_\_\_\_\_ PCN: \_\_\_\_\_

Group #:

ID#:

Medical (Name, ID#, Group#):

☐ Offsite Clinic Clinic Name:

Clinic Address:

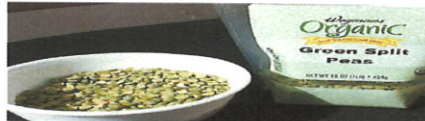
ICIMZIV 202306



## Price Increase Effective October 1, 2023

In keeping pace with the cost of food and staffing, Generation Station LLC will have to increase pricing to \$85 per day, adding an additional \$5 to the cost of attendance.

### **Why Are Split Peas the Best Carbs to Help You Poop?**



Split peas can help ease constipation in several ways. For one, they're teeming with fiber, a must-have nutrient for constipation relief. They're especially rich in soluble fiber, which draws a lot of water into your gastrointestinal tract, helping to make your stool a normal consistency so pooping is more comfortable. (Fact: 2021 research from [Nutrients](#) shows that normal poop is about 74% water, while hard, constipation poop is less than 72% water, so increasing the hydration in your stool could be a very good thing.) Split peas also contain insoluble fiber—a kind that increases water absorption, stool bulk and intestinal regulation. All of these factors can make it easier to have bowel movements, according to a 2021 review of studies published in [Legume Science](#).

A 1-cup serving of cooked split peas contains 16 grams of total dietary fiber—getting you closer to the 25 to 34 grams that the 2020-2025 [Dietary Guidelines for Americans](#) recommend adults get each day. Just remember that upping your fiber intake too much, too quickly can worsen constipation. So be sure to drink lots of water and slowly add more fiber to your diet over time to keep things moving.

Split peas also contain another type of fiber known as resistant starch—aptly named because it resists digestion in your small intestines. Once they reach your colon, resistant starches are broken down and fermented by your gut bacteria, producing short-chain fatty acids including one called butyrate. Butyrate functions as an energy source for your intestinal lining, and it may act on cells involved in regulating gut motility, making it easier for stool to move through your intestines, a process controlled by the [enteric nervous system](#), according to a 2021 review of studies published in the journal [Nutrients](#).

Resistant starches have prebiotic powers, as well—meaning they feed your good gut bacteria and promote better microbiome health, which has been linked to regularity. Poor gut health has the opposite effect, according to a 2019 review published in the journal [Frontiers in Medicine](#). Additionally, a 2017 review published in [The American Journal of the Medical Sciences](#) that included five randomized control trials found that consuming prebiotic foods like split peas increased weekly stool frequency in adults with constipation.

And the benefits don't end there. Split peas have one of the highest amounts of protein in the legume family, with 16 grams per [cup](#) (cooked). While protein doesn't help constipation




directly, it's one of the food groups you might want to skip when you're backed up and feeling bloated and full. But going without food can drain your energy. And the complex carbs that peas deliver can counter that fatigue without feeling like you're eating something heavy. Plus, they're inexpensive, accessible in most stores and can hang around for a long time in your pantry.

## Attention: Access Link Riders

### EARN A \$20 EZ-WALLET CREDIT:

Testing for the next phase of Replicant our Virtual Assistant software will start soon. This next phase offers another option for making reservations to or from existing destinations. Sign-up today by sending an email with your name, Access Link ID number, cell phone number, and email address to [Accesslinkuat@njtransit.com](mailto:Accesslinkuat@njtransit.com). Volunteers will receive additional information including instructions for receiving the EZ-Wallet credit. If you need assistance with volunteering, please contact the Access Link Customer Service Group at 973-491-4224 by selecting option # 5. We appreciate your willingness to help us make Access Link better for everyone.

SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY
					1	2
3	4 	5 Burgers, Fries Side Salad Dessert	6 Hot Breakfast  Lite Lunch	7 Pork Chop Mashed Potatoes Veggies, Dessert	8 <b>CLOSED</b>	9
10 	11 <b>CHEF'S CHOICE</b>	12 Spaghetti with Meatballs Side Salad Dessert	13 Hot Breakfast  Lite Lunch	14 Everybody's Birthday 	15 <b>CLOSED</b>	16 
17	18 <b>CHEF'S CHOICE</b>	19 Chicken Sandwich, lettuce, tomato, Macaroni	20 Hot Breakfast  Lite Lunch	21 Meatloaf Mashed Potatoes Veggies Dessert	22 <b>CLOSED</b>	23 
24	25 <b>CHEF'S CHOICE</b> 	26 Italian Sausage & Peppers on Roll Chips Dessert	27  Hot Breakfast Lite Lunch	28 Shot Clinic Meatball Subs Chips, Dessert 	29 <b>CLOSED</b>	30



## Protection in Just 1 Dose

**Pprevnar<sup>20</sup>**  
Pneumococcal 20-valent  
Conjugate Vaccine

The Centers for Disease Control and Prevention recommends that **adults with certain underlying medical conditions**, including...

- Asthma
- COPD
- Diabetes
- Chronic heart disease

... **As well as those who...**

- Take certain immunosuppressive drugs
- Smoke cigarettes

... **Get vaccinated against pneumococcal pneumonia.**

**Pprevnar 20® (Pneumococcal 20-valent Conjugate Vaccine)** provides protection in just 1 dose.

Just 1 dose of the Pprevnar 20 vaccine helps protect eligible adults against 20 strains of the bacteria that cause pneumococcal pneumonia.

**Ask your pharmacist if Pprevnar 20  
is right for you.**

**Please see accompanying full Prescribing Information for Pprevnar 20.**

### SELECT SAFETY INFORMATION

- In adults 18 years of age and older, the most common side effects were pain at the injection site, muscle pain, fatigue, headache, and joint pain. Additionally, injection site swelling was also common in adults 18 through 59 years of age
- Ask your healthcare provider about the risks and benefits of Pprevnar 20. Only a healthcare provider can decide if Pprevnar 20 is right for you

### INDICATION FOR PREVNAR 20

- Pprevnar 20 is a vaccine indicated for active immunization for the prevention of pneumonia and invasive disease caused by *Streptococcus pneumoniae* serotypes 1, 3, 4, 5, 6A, 6B, 7F, 8, 9V, 10A, 11A, 12F, 14, 15B, 18C, 19A, 19F, 22F, 23F, and 33F in adults 18 years of age and older
- The indication for preventing pneumonia caused by *S. pneumoniae* serotypes 8, 10A, 11A, 12F, 15B, 22F, and 33F is approved based on immune responses. Continued approval may depend on a supportive study

Manufactured by Wyeth Pharmaceuticals LLC.  
PP-PNR-USA-0773 © 2022 Pfizer Inc.  
Printed in the USA/October 2022

Marketed by Pfizer Inc.  
All rights reserved.



## You could be at risk for pneumococcal pneumonia

If you are 19–64 years old, has a doctor ever told you that you have



Asthma



Diabetes



COPD



Chronic heart  
disease

**Do you take certain medicines that suppress the immune system?**

**Are you age 65 or older?**

If any of these apply to you, then you are at higher risk for developing pneumococcal pneumonia.

### What is pneumococcal pneumonia?

Pneumococcal pneumonia is a type of pneumonia caused by bacteria called pneumococcus. It can sometimes be a serious complication of the flu.

Pneumococcal pneumonia

- Can spread through coughing or close contact
- Has some symptoms that can last for weeks
- Can put you in the hospital

In rare cases, pneumococcal pneumonia can cause death.

The good news is that **there are vaccines to help prevent pneumococcal pneumonia.** Turn over this page to learn more.

COPD = chronic obstructive pulmonary disease.

### SELECT SAFETY INFORMATION

- Pprevnar 20® (Pneumococcal 20-valent Conjugate Vaccine) should not be given to anyone with a history of severe allergic reaction to any component of Pprevnar 20 or to diphtheria toxoid
- Adults with weakened immune systems may have a lower response to Pprevnar 20. Safety data are not available for these groups. Your healthcare provider can tell you if Pprevnar 20 is right for you

**Please see Indication and additional Select Safety Information on reverse side.**

**Pprevnar<sup>20</sup>**  
Pneumococcal 20-valent  
Conjugate Vaccine