



FOOMKA OGGOLAANSHAHA EE TALLAALKA DUGSIGA

Magaca Dambe ee Ardayga: _____ Magaca Koobaad ee Ardayga: _____

Taariikhda dhalashada: _____ YYYY/MM/DD _____

Dugsiga: _____ Fasalka: _____

Ka jawaab afarta su'aalood ee ku saabsan taariikhda ilmahaaga Haddii aad ku jawaabto "haa", si kooban u sharrax.

- | | | |
|---|-------------------------------|-------------------------------------|
| 1. Ardaygu ma leeyahay xaalad caafimaad oo halis ah? | <input type="checkbox"/> Maya | <input type="checkbox"/> Haa: _____ |
| 2. Ardaygu ma qaataa wax daawo ah? | <input type="checkbox"/> Maya | <input type="checkbox"/> Haa: _____ |
| 3. Ardaygu weligii wax xasaasiyad ah ma ku yeeshay tallaalka? | <input type="checkbox"/> Maya | <input type="checkbox"/> Haa: _____ |
| 4. Ardaygu ma leeyahay taariikh suuxdin ama qalal? | <input type="checkbox"/> Maya | <input type="checkbox"/> Haa: _____ |
| 5. Ardaygu ma leeyahay wax xasaasiyad ah? | <input type="checkbox"/> Maya | <input type="checkbox"/> Haa: _____ |

Fadlan ku muuji oggolaanshahaaga "HAA" (tallaala) ama "MAYA" (HA tallaalin) tallaalka KASTA. Foomka oggolaanshahani wuxuu shaqaynayaa ilaa 24 bilood haddii aan oggolaanshaha looga noqon hadal ahaan ama qoraal ahaan ama qoraal Caafimaadka Dadweynaha Ottawa.

Tallaalka Meningokokal ee Isku dhafan ACYW-135 (loogu baahan yahay imaanshaha dugsiga)
Waan akhriyay xaashida macluumaadka tallaalka. Waxaan fursad u helay inaan weydiyo su'aalo oo laga jawaabay oo aan ku qancay. Waan fahamsanahay faa'iidooyinka iyo khatarta la xiriirta tallaalka. Waxaan oggolaaday kalkaaliye caafimaad oo u shaqeeya Ottawa Puplic Health si ay u siiyaan tallaalka Meningokokal (**hal qiyaas**).

Haa Magacyada: _____
 Maya Magacyada: _____

Tallaalka Cagaarshowga B (HB)
Waan akhriyay xaashida macluumaadka tallaalka. Waxaan fursad u helay inaan weydiyo su'aalo oo laga jawaabay oo aan ku qancay. Waan fahamsanahay faa'iidooyinka iyo khatarta la xiriirta tallaalka. Waxaan oggolaaday kalkaaliye caafimaad oo u shaqeeya Ottawa Puplic Health si ay u siiyaan tallaalka Cagaarshowga B (**2 qiyaasood oo la siiyo 6dii bilood mar**).

Haa Magacyada: _____
 Maya Magacyada: _____

Tallaalka Babilimofayras ee Dadka (HPV)
Waan akhriyay xaashida macluumaadka tallaalka. Waxaan fursad u helay inaan weydiyo su'aalo oo laga jawaabay oo aan ku qancay. Waan fahamsanahay faa'iidooyinka iyo khatarta la xiriirta tallaalka. Waxaan oggolaaday kalkaaliye caafimaad oo u shaqeeya Ottawa Puplic Health si ay u siiyaan tallaalka HPV (**2 qiyaasood 6dii bilood mar.**)

Haa Magacyada: _____
 Maya Magacyada: _____

Magaca Dhammaystiran ee Masuulka Sharciga ah (daabac): _____ Xiriirka: _____

Saxeexa Masuulka Sharciga ah: _____ Taariikhda: _____ YYYY/MM/DD _____

Saxeexa Ardayga: _____ Taariikhda: _____ YYYY/MM/DD _____

Macluumaadka Caafimaadka Shaqsiyeedka waxaa lagu soo ururiyaa iyadoo la raacayo awoodda Qaybta 5 ee *Xeerka Ilaalinta iyo Horumarinta Caafimaadka* waxaana loo isticmaali doonaa in lagu maamulo tallaalka ay ku jirto ilaalinta diiwaanka tallaalka ee tallaalka. Su'aalaha ku saabsan ururinta iyo isticmaalka macluumaadka caafimaadka shakhsi ahaaneed waxaa lagu hagaajin karaa Kormeeraha, Unugga Tallaalka, Caafimaadka Dadweynaha Ottawa boostada 100 Constellation Drive, Ottawa, ON K2G 6J8, telifoonka 613-580-6744, ama iimayl ahaan halkan:

<https://ottawa.ca/en/city-hall/open-transparent-and-accountable-government/access-information-and-protection-privacy/protection-privacy/personal-health-information-protection>

SCHOOL VACCINE ASSESSMENT FORM (This side for clinic use only)

Student Last name: _____ Student First name: _____

Date of birth: _____ YYYY/MM/DD _____ Age: _____

Client ID: _____

Administer the checked vaccines	Consent Obtained <i>(Initial)</i>	Panorama Verified		Dose Number
		Correct Interval <i>(Initial)</i>	Requires Dose <i>(Initial)</i>	
<input type="checkbox"/> Men-C-ACYW-135				_ / 1
<input type="checkbox"/> HB				_ / _
<input type="checkbox"/> HPV				_ / _

Assessor Signature and Designation: _____ Date: _____

I have used two client identifiers and the client has no contraindications to receiving the vaccine(s) based on the review of all screening questions. Initial & Designation: _____

Menactra®

Nimenrix®

Engerix®-B Recombivax®

Gardasil®9

Lot number

Diluent
(Nimenrix® only)

Lot number

Lot number

Dosage and Route:

0.5ml Intramuscular

Site:

- Left Deltoid
 Right Deltoid

Administration:

Time: _____

Date: _____

Signature and Designation:

Dosage and Route:

- 1.0ml Intramuscular
 0.5ml Intramuscular

Site:

- Left Deltoid
 Right Deltoid

Administration:

Time: _____

Date: _____

Signature and Designation:

Dosage and Route:

0.5ml Intramuscular

Site:

- Left Deltoid
 Right Deltoid

Administration:

Time: _____

Date: _____

Signature and Designation:

Clinical Notes (date and time): _____

Signature and Designation: _____

Initial when data entered in Panorama: _____

Date data entered in Panorama : _____