Ottawa | Public Health
Santé publique

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? ☐ Maya ☐ Haa: _________________________
2. Ardaygu ma qaataa wax daawo ah? ☐ Maya ☐ Haa: _________________________
3. Ardaygu weligii wax xasaasiyad ah ma ku yeeshay tallaal? ☐ Maya ☐ Haa: _________________________
4. Ardaygu ma leeyahay taariikh suuxdin ama qalal? ☐ Maya ☐ Haa: _________________________
5. Ardaygu ma leeyahay wax xasaasiyad ah? ☐ Maya ☐ Haa: _________________________

Fadlan ku muuji oggolaanshahaaga "HAA" (tallaala) ama "MAYA" (HA tallaalin) tallaal 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 weydiiyo su'aalo oo laga jawaabay oo aan ku qancay. Waan fahamsanahay faa'iidooyinka iyo khatarta la xiriirta tallaalkan. 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 weydiiyo su'aalo oo laga jawaabay oo aan ku qancay. Waan fahamsanahay faa'iidooyinka iyo khatarta la xiriirta tallaalkan. 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 weydiiyo su'aalo oo laga jawaabay oo aan ku qancay. Waan fahamsanahay faa'iidooyinka iyo khatarta la xiriirta tallaalkan. 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 tallaalada ay ku jirto ilaalinta diiwaanka tallaalka ee tallaalada. Su'aalaha ku saabsan ururinta iyo isticmaalka macluumaadka caafimaadka shakhsi ahaaneed waxaa lagu hagaajin karaa Kormeeraha, Unugga Talaalka, 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 *(Initial)*	Panorama Verified		Dose Number
		Correct Interval *(Initial)*	Requires Dose *(Initial)*	
☐ **Men-C-ACYW-135**				__/ 1
☐ **HB**				__/__
☐ **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®**

_______________ Lot number

_________________ Diluent (Nimenrix® only)

Dosage and Route:

☐ 0.5ml Intramuscular

Site:

☐ Left Deltoid

☐ Right Deltoid

Administration:

Time:_____________________

Date:_____________________

Signature and Designation:

____

Engerix®-B **Recombivax®**

_______________________ Lot number

Dosage and Route:

☐ 1.0ml Intramuscular

☐ 0.5ml Intramuscular

Site:

☐ Left Deltoid

☐ Right Deltoid

Administration:

Time:_____________________

Date:_____________________

Signature and Designation:

____

Gardasil®9

_______________________ Lot number

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 : ______________________