

Isbahaysiga Tallaalka Indiana (IIC) - Foomka Diiwangelinta iyo Oggolaanshaha

6919 E 10th Street, Suite C2, Indianapolis, IN 46219

Ku buuxi xogta qofka la tallaalo:

Magaca Sharciga ee Bukaanka: Magaca koowaad _____ Magaca dhexe _____
 Magaca Saddexaad: _____
Magaca La Doortay (*haddii ay mudan tahay*): _____ **Shaqada** (*haddii ay mudan tahay*): _____
Taleefanka #: (____) - ____ - ____ **T. Dhalashada:** ____/____/____ **Da'da:** ____ **Jinsiga** (laguu aqoonsaday markaad dhalatay): ☐ Dheddig ☐ Lab
Cinwaanka Boostada: _____ **Caasimadda:** _____ **Gobolka:** ____ **Baaqa Boostada:** _____
Isirka: (Calaamadee dhammaan kuwa khuseeyo) ☐ Hindida Maraykanka/Dhaladka Alaska ☐ Aasiyaan ☐ Madow ☐ Dhaladka Hawaiian/Deganaha
 Jasiiradda Baasifik ☐ Cadaan ☐ Isir kale _____
Qowmiyadda: ☐ Hisbaanik/Latino ☐ Aan ahayn Hisbaanik/Latino **Magaca Saddexan ee Waalidka/Mas'uulka:** _____
Loogu talagalay Ardayga: Magaca Dugsiga: _____ Fasalka: _____

Xaallada Caymiska (Calaamadee sanduuqa)

☐ AAN LAHAYN CAYMIS

<input type="checkbox"/> KAALMADA-DAWO (MEDICAID) <input type="checkbox"/> HHW <input type="checkbox"/> HCC <input type="checkbox"/> HIP <input type="checkbox"/> CHIP Shirkadda: _____ Medicaid #: _____	<input type="checkbox"/> XANAANO-DAWO Medicare #: _____ # Aqoonsiga Xubnaha / Kooxda (haddii ay khuseyso): _____
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☐ CAYMISKA GAAR AH ama GANACSI (AAN AHAYN MEDICAID) *Foomka ku dheji koobiga kaarka haddii ay suurtagal tahay*
 Shirkadda: _____ Caymiska/ Aqoonsiga Xubinta: _____ # Kooxda: _____
 Magaca Mulkiilaha Caymiska: _____ Taariikhda Dhalashada Mulkiilaha: ____/____/____
 Waxa ay Isku yihiin Mulkiilaha Caymiska iyo Bukaanka: _____

Su'aalaha Baadhista Caafimaadka ee Qofka la Tallaalo:

	(no)	(yes)
1. Miyaad maanta jirran tahay?	<input type="checkbox"/> Maya	<input type="checkbox"/> Haa
2. Ma jiraan wax xasaasiyad ah oo ku saabsan daawada, cuntooyinka, walxaha tallaalka, ama cinjirka? Fadlan liis garey xasaasiyadaha:	<input type="checkbox"/> Maya	<input type="checkbox"/> Haa
3. Weligaa ma yeelatay fal-celin xasaasiyadeed oo halis ah ka dib markii aad qaadatay tallaalka? Hadday haa tahay, fadlan sharax:	<input type="checkbox"/> Maya	<input type="checkbox"/> Haa
4. Weligaa ma kugu dhacay Cudurka Difaaca Jirkaagu uu Weeraro Dareemahaaga (Guillain-Barre Syndrome (GBS))?	<input type="checkbox"/> Maya	<input type="checkbox"/> Haa
5. Miyaad qabtaa dhibaato caafimaad oo daba-dheerato oo ku saabsan wadnaha, sambabada ama kelyaha, cudurada dheef-shiid kiimikaadka (tusaale ahaan sokorowga) ama xanuunada kale ee dhiiga (tusaale xinjirowga, dhiig la'aanta unugyada (sickle cell))?	<input type="checkbox"/> Maya	<input type="checkbox"/> Haa
6. Ma qabtaa kansar, kansarka dhiigga, AIDS ama cudur kale oo daciifiyo hab-dhiska difaaca jirka?	<input type="checkbox"/> Maya	<input type="checkbox"/> Haa
7. Miyaad qabtaa qalal ama dhibaato maskaxeed ama dhibaato kale oo hab-dhiska dareenka?	<input type="checkbox"/> Maya	<input type="checkbox"/> Haa
8. Miyaad qaadataa cortisone, prednisone, steroids kale ama daawooyinka kansarka ka hortaga, ama ma qaadatay daawaynta raajo ee kansarka?	<input type="checkbox"/> Maya	<input type="checkbox"/> Haa
9. Khuseyso Dumarka - Miyay uur bay leedahay mise waxaa jirta fursad ay uur ku qaadi karto bisha xigta?	<input type="checkbox"/> Maya	<input type="checkbox"/> Haa
10. Miyaad sigaar ama shiishad (vape) cabtaa? Waligaa ma cabtay sigaar ama shiishad?	<input type="checkbox"/> Maya	<input type="checkbox"/> Haa
11. Sanadkii la soo dhaafay, ma lagugu shubay dhiig ama lagu siiyay badeecooyin dhiig, ama lagu siiyay lid-jidh gale dhaliye (difaaca jirka) ama daawo fayraska ka hortagto?	<input type="checkbox"/> Maya	<input type="checkbox"/> Haa
12. Miyaad qaadatay wax tallaalka ah 4-tii toddobaad ee la soo dhaafay?	<input type="checkbox"/> Maya	<input type="checkbox"/> Haa

Bayaanka Oggolaanshaha

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Oggolaanshaha Isticmaalka Macluumaadka Caafimaadka Dhawrsan & Meelaynta Sheegashada: Waxaan halkan ku ogolaaday oo aan qirayaa helitaanka Ogeysiiska Qarsoonnimada
Dhaqanada ku saabsan isticmaalka iyo siidaynta xogtayda caafimaadka gaarka ah ee ujeedada hawlgallada daryeelka caafimaadka, oo ay weheliso u-dejinta dhammaan lacag-bixinta caymis-bixiyaha kor ku taxan oo loo dirayo biilasha qolo saddexaad ee la xiriira adeegyada halkan lagu soo bandhigay.

***Saxiixa: X**

Taariikhda:

Saxiixa waalidka/mas'uulka ayaa loo baahan yahay haddii ay da'doodu ka yar tahay 18 jir

Oggolaanshaha Tallaalka: Saxiixayga foomkan wuxuu muujinayaa inaan codsaday in tallaalka hoos lagu tilmaamay uu wakiilka ka socdo Isbahaysiga Tallaalka Indiana (IIC) i siiyo ama siiyo ku tiirsanahayga. Waxaan mas'uuliyad kasta ee falcelin xasaasiyadeed kasta oo dhaca ka dhaafayaa

qaan-sheegtaha dhinaca saddexaad, IIC, qofka maamulka hayo, iyo shaqaalaha. Waxaan si shuruud la'aan ah oo aan laga noqon karin uga tanaasulayaa xuquuq kasta oo aan ku heli karo maxkamad xeerbeegti ah, ilaa xadka ugu badan ee sharcigu oggol yahay, dacwad kasta ama fal kasta oo ka soo baxa ama la xidhiidha adeeggan, iyo in dacwad kasta ama tallaabo kasta oo noocaas ah lagu go'aamiyo

si shakhsiyeed iyada oo loo marayo dhexdhexaadin si waafaqsan Xeerarka Xalinta Khilaafaadka Ganacsiga ee Ururka Xalinta Khilaafaadka Maraykanka.

Aniga ama IIC ama qaan-sheegataha dhinaca saddexaad midna xaq uma yeelan doono ku biiridda ama xoojiyo dacwadaha dhex dhexaadinta ama ka dhanka ah shaqsiyaadka ama hay'adaha kale, ama u garqaado wixii sheegasho ah xubinta matala heer ahaan ama matalaadda guud ee awooda qareenka. Haddii ay u baylihida kaaga timaaddo shaqada, IIC waxay haysataa oggolaanshaha bukaanka ee baaritaanka dhiigga ee bukaanka iyo badbaadada shaqaalaha si isku mid ah.

Waan akhriyay ama la ii sharxay macluumaadka ka soo baxay Bayaannada Macluumaadka Tallaalka oo waan fahmay khataraha (oo ay ku jiraan falcelinta xasaasiyadeed ee daran) iyo dheefaha tallaalka. Haddii aan oggolaansho u bixinayo qof kale, waxaan leeyahay awoodda sharciyeed, oo ku saleysan xiriirka aan la leeyahay qofka kor lagu tilmaamay, ee aan ku oggolaanayo bixinta tallaalkan.

Waxaan oggolahay in naftayda/ilmahayga la siiyo dhammaan tallaallada lagu taliyey ee wakhtigooda la joogo. Haddii aan rabo inaan diido wax tallaalka ah oo gaar ah,

markaas waxaan waci doonaa 317-628-7116, iimayl u diri doonaa: clinic@vaccinateindiana.org ama kala hadli doona hogaanka rugta caafimaadka.

Tallaalada ayaa laga yaabaa in la siiyo adiga iyo/ama ilmahaaga iyadoo lagu salaynayo diiwaanka tallaalka: DTaP/Tdap, Cagaarshowga A, Cagaarshowga B, Haemophilus influenzae nooca b (HiB), Human Papillomavirus (HPV), Hargabka, Jadeecada, Qaamo-qashiirta iyo Jadeeco Jarmalka (MMR), Qoorgooyaha (Meningitis), Dabaysha, Burkiitada, Rotavirus, Fayraska Isku-dhafka Neefsiga ah (RSV), Varicella, Zoster, iyo/ama Covid-19.

***Saxiixa: X**

Taariikhda:

Saxiixa waalidka/mas'uulka ayaa loo baahan yahay haddii ay da'doodu ka yar tahay 18 jir

CLINIC USE ONLY - Note any vaccine refusals next to vaccine name

Vaccine	VIS	MANUFACTURER/LOT #/ EXP DATE	INJECTION SITE	ROUTE
Dtap 6 weeks - 6 years	8/6/21		<input type="checkbox"/> L arm <input type="checkbox"/> R arm <input type="checkbox"/> L thigh <input type="checkbox"/> R thigh	<input type="checkbox"/> IM
Dtap/IPV 4 years - 6 years	1/31/25		<input type="checkbox"/> L arm <input type="checkbox"/> R arm <input type="checkbox"/> L thigh <input type="checkbox"/> R thigh	<input type="checkbox"/> IM

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Dtap/Hep B/IPV 6 weeks-6 years	1/31/25		<input type="checkbox"/> L arm <input type="checkbox"/> L thigh	<input type="checkbox"/> R arm <input type="checkbox"/> R thigh	<input type="checkbox"/> IM
Dtap/Hib/IPV 6 weeks - 4 years	1/31/25		<input type="checkbox"/> L arm <input type="checkbox"/> L thigh	<input type="checkbox"/> R arm <input type="checkbox"/> R thigh	<input type="checkbox"/> IM
Dtap/IPV/Hib/HepB 6 weeks - 4 years	1/31/25		<input type="checkbox"/> L arm <input type="checkbox"/> L thigh	<input type="checkbox"/> R arm <input type="checkbox"/> R thigh	<input type="checkbox"/> IM
Hep A <input type="checkbox"/> adult 19 yr and up <input type="checkbox"/> pediatric 1 yr - 18 yr	1/31/25		<input type="checkbox"/> L arm <input type="checkbox"/> L thigh	<input type="checkbox"/> R arm <input type="checkbox"/> R thigh	<input type="checkbox"/> IM
Hep B (2 dose series) 18 years and up	1/31/25		<input type="checkbox"/> L arm <input type="checkbox"/> L thigh	<input type="checkbox"/> R arm <input type="checkbox"/> R thigh	<input type="checkbox"/> IM
Hep B (3 dose series) <input type="checkbox"/> adult 20 yrs and up <input type="checkbox"/> pediatric Birth-19 yrs	1/31/25		<input type="checkbox"/> L arm <input type="checkbox"/> L thigh	<input type="checkbox"/> R arm <input type="checkbox"/> R thigh	<input type="checkbox"/> IM
Hib 6 weeks - 4 years	8/6/21		<input type="checkbox"/> L arm <input type="checkbox"/> L thigh	<input type="checkbox"/> R arm <input type="checkbox"/> R thigh	<input type="checkbox"/> IM
HPV 9 yrs - 45 yrs	8/6/21		<input type="checkbox"/> L arm	<input type="checkbox"/> R arm	<input type="checkbox"/> IM
Influenza 6 mos and up High Dose - 65yrs & up	1/31/25		<input type="checkbox"/> L arm <input type="checkbox"/> L thigh	<input type="checkbox"/> R arm <input type="checkbox"/> R thigh	<input type="checkbox"/> IM
MCV4 1st dose: 10-15 yrs 2nd dose: 16 and up	1/31/25		<input type="checkbox"/> L arm	<input type="checkbox"/> R arm	<input type="checkbox"/> IM
Men B 16 yrs - 23 yrs Bexsero / Trumenba	1/31/25		<input type="checkbox"/> L arm	<input type="checkbox"/> R arm	<input type="checkbox"/> IM
MMR 1 year - 64 years	1/31/25		<input type="checkbox"/> L arm <input type="checkbox"/> L thigh	<input type="checkbox"/> R arm <input type="checkbox"/> R thigh	<input type="checkbox"/> SC
MMRV 3 yrs - 12 yrs	1/31/25		<input type="checkbox"/> L arm <input type="checkbox"/> L thigh	<input type="checkbox"/> R arm <input type="checkbox"/> R thigh	<input type="checkbox"/> SC
Pneumococcal 6 weeks - 4 years 50 years and up	5/12/23		<input type="checkbox"/> L arm <input type="checkbox"/> L thigh	<input type="checkbox"/> R arm <input type="checkbox"/> R thigh	<input type="checkbox"/> IM
Polio 6 weeks and up	1/31/25		<input type="checkbox"/> L arm <input type="checkbox"/> L thigh	<input type="checkbox"/> R arm <input type="checkbox"/> R thigh	<input type="checkbox"/> IM <input type="checkbox"/> SC
Rotavirus 6 weeks - 8 mos.	10/15/21				<input type="checkbox"/> PO
RSV Infants - 19 mos. 60 yrs and up	1/31/25		<input type="checkbox"/> L arm	<input type="checkbox"/> R arm	<input type="checkbox"/> IM
Tdap 7 years and up	1/31/25		<input type="checkbox"/> L arm	<input type="checkbox"/> R arm	<input type="checkbox"/> IM
Varicella 1 year and up	1/31/25		<input type="checkbox"/> L arm <input type="checkbox"/> L thigh	<input type="checkbox"/> R arm <input type="checkbox"/> R thigh	<input type="checkbox"/> SC
Zoster 50 yrs and up	2/4/22		<input type="checkbox"/> L arm	<input type="checkbox"/> R arm	<input type="checkbox"/> IM
COVID	1/31/25		<input type="checkbox"/> L arm	<input type="checkbox"/> R arm	<input type="checkbox"/> IM

VACCINATOR NAME AND CREDENTIALS: _____ DATE: _____