職員專用	
❑Regular	❑50-64yrs ❑PW
❑DA Recipients	❑≥65yrs

2018/19 基督教聯合那打素社康服務 UNITED CHRISTIAN NETHERSOLE COMMUNITY HEALTH SERVICE

ADULT Consent Form

INFLUENZA VACCINATION SERVICE

Quadrivalent influenza vaccine will be offered
FLUARIX TETRA (Quadrivalent) • GlaxoSmithKline (GSK)
Manufactured in Germany

*For mentally capacitated persons at 18 years of age or over
*Each participant should fill in his/her own consent

A1) RECIPIENT'S PERSONAL DETAILS (as indicated on identity document)

Name :

Organization Name (if applicable):

Age : Sex: ❑ M ❑ F

A2) Government Vaccination Subsidy

Please complete all the boxes on right side:

I am a HK resident and I am a:
- Person aged 50 years old or above
- Pregnant woman
- Disability Allowance Recipient

Note : Government subsidy can only be claimed upon presentation of a valid Hong Kong resident identity document and other required documentary proofs. If inaccurate/ inadequate information was given, the person may fail to apply for the Government Subsidy, and shall be required to return the cost of this vaccination

HKID No.: ( )

Date of Birth: D M Y

HK Identity Card Issue Date:
All digits stated on the Left Bottom Corner
D M Y

B) RECIPIENT'S HEALTH RECORD

Please select the most suitable answer and mark a ☑ in the appropriate boxes below:

1. Is this your first ever influenza vaccination? ❑ Not sure ❑ Yes ❑ No
2. Are you allergic to egg? Or have you ever had allergy or other bad reaction to any vaccine or medication? If yes, please specify : ❑ Yes ❑ No
   Egg Allergy : ❑ Rash ❑ Numbness/ Swelling ❑ Others:_____
   The name of vaccine(s)/ drug(s) and reaction(s) :_____
3. Have you ever experienced any limb numbness or weakness, or allergic reactions after receiving seasonal influenza vaccination? ❑ Yes ❑ No
4. Are you suffering from any bleeding disorders or on blood thinners? ❑ Yes ❑ No
5. (On vaccination day) Does the recipient have fever or feel sick? ❑ Yes ❑ No

I declare that the information given above is correct and I consent to receiving the 2018/19 influenza (Quadrivalent) vaccination.

(or finger print if illiterate)

Signature of recipient :
Contact Telephone Number of recipient **(must fill-in)** : Date:

STAFF USE ONLY

Prescription : Fluarix Tetra (Quadrivalent) 2018/19 strains 0.5ml x 1 dose

UCN: ❑OR ❑WL ❑BKT ❑JD ❑KF ❑TSW ❑CC Medical No. :

Doctor: Signature:

Batch No.: Given by: Date:

基督教聯合那打素社康服務 UNITED CHRISTIAN NETHERSOLE COMMUNITY HEALTH SERVICE

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2018/19 INFLUENZA VACCINATION SERVICE

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Manufactured in Germany

Guidelines for Influenza Vaccination

Quadrivalent influenza vaccine is proved to be effectively protected against the following Influenza viruses:

1. an A/Michigan/45/2015 (H1N1)pdm09-like virus
2. an A/Singapore/INFIMH-16-0019/2016 (H3N2)-like virus
3. a B/Colorado/06/2017-like virus
4. a B/Phuket/3073/2013-like virus

Who should have the Influenza vaccination (Intramuscular Injection)?

People aged 6 months or above, especially for :
- Pregnant Women
- Elderly persons living in residential care homes
- Long-stay residents of institutions for the Persons with Disabilities
- Persons aged 50 years or above
- Persons with chronic medical problems
- Health care workers
- Children between the age of 6 months to 11 years (less than 12 years)
- Poultry workers
- Pig farmers and pig-slaughtering industry personnel
- Persons who have frequent influenza infections and illness

Do not use Influenza vaccine (Intramuscular Injection) in the event of:
- Children aged <6 months
- Having allergic reactions to egg or any other components of the influenza vaccine
- Fever, acute infection or severe discomforts found on vaccination day (please delay the vaccination)
- For people having past history of Guillian-Barre Syndrome (Please consult personal family doctor first before receiving the vaccination).

Dosage

- For above the age of 9 years old: Annual vaccinations are recommended
- For Children <9 years who have never received influenza vaccination before should ideally have 2 doses given 4 weeks apart

Possible side effect

- Local reactions may include redness/ tenderness and swelling of injection site. Systemic reactions may include mild fever, influenza-like symptoms, malaise and fatigue beginning 6 to 12 hours after vaccination and lasting up to two days.
- Serious adverse events may include:
  Guillain-Barre Syndrome (~1 to 2 case per million vaccinees).
  Meningitis or encephalopathy (~1 in 3 million doses distributed).
  Severe allergic reaction (anaphylaxis) (~9 in 10 million doses distributed).

Additional Tips for prevention of influenza: Regular exercise, balanced diet, and adequate rest. Avoid going to overcrowded areas in influenza peak season. Maintain good personal & environmental hygiene.

Contact Us

Outreach Service : 2357-4008

Kwun Tong	Lam Tin	Ngau Tau Kok	Jordan	Tai Po	Tin Shui Wai
Jockey Club Wo Lok CHC	Bradbury Kwong Tin CHC	UCN Cheerful Health Centre	UCN Jordan CHC	Kwong Fuk CHC	Jocky Club Tin Shui Wai CHC
Unit 26-33, G/F, Kui On Hse, Wo Lok Estate, Hip Wo Street	Unit 203, Kwong Tin Shopping Ctr, Kwong Tin Estate	1/F, Cheerful Court, 55 Choi Ha Road, Ngau Tau Kok	13/F, Sino Cheer Plaza, No 23 Jordan Road	No 19, G/F, Kwong Yan House, Kwong Fuk Estate	Unit 103, 1/F, Tin Ching Amenity and Community Building, Tin Ching Estate
2344-3444	2340-3022	2230-0200	2770-8365	2638-3846	3156-9000

基督教聯合那打素社康服務
UNITED CHRISTIAN NETHERSOLE COMMUNITY HEALTH SERVICE

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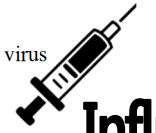

Guidelines for Influenza Vaccination

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  Severe allergic reaction (anaphylaxis) (~9 in 10 million doses distributed).

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✆2344-3444	✆2340-3022	✆2230-0200	✆2770-8365	✆2638-3846	✆3156-9000

職員專用
❑Regular ❑CIVSS ❑50-64yrs
❑≥65yrs ❑PW ❑DA Recipients ❑PIDVSS

2018/19 基督教聯合那打素社康服務 UNITED CHRISTIAN NETHERSOLE COMMUNITY HEALTH SERVICE

INFLUENZA VACCINATION SERVICE

Quadrivalent influenza vaccine will be offered
FLUARIX TETRA (Quadrivalent) • GlaxoSmithKline (GSK)
Manufactured in Germany

Parent/Guardian Consent Form

This consent form MUST be completed by parent/ guardian of
* persons under 18 years of age/ mentally incapacitated
* Each participant should fill in his/her own consent

A1) RECIPIENT'S PERSONAL DETAILS
(as indicated on identity document)

Name :

Age: Sex: ❑M ❑F

Date of Birth : D M Y

Organization Name (if applicable):

Class: Class No.:

A2) Government Vaccination Subsidy
Please complete all the boxes on right side:

Applicant is a HK resident and he/she is a:

- Child aged 6 months to under 12 years/ attending a primary school in HK at the time of vaccination
- Person with intellectual disabilities / Disability Allowance Recipient
- Person aged 50 years old or above (the recipient is mentally incapacitated)

Note : Government subsidy can only be claimed upon presentation of a valid Hong Kong resident identity document and other required documentary proofs. If inaccurate/ inadequate information was given, the person may fail to apply for the Government Subsidy, and shall be required to return the cost of this vaccination

HK Birth Certificate Registration Number:
( )

HKID No*./other identity document:
*For Persons **aged 11 or above** must use Hong Kong Identity Card

Issue Date:
D M Y

B) RECIPIENT'S HEALTH RECORD

Please select the most suitable answer and mark a ☑ in the appropriate boxes below:

1. Is this the first ever influenza vaccination for the recipient? ❑Not sure ❑Yes ❑ No
2. Is the recipient allergic to egg? Or have ever had allergy or other bad reaction to any vaccine or medication? If yes, please specify : ❑Yes ❑ No
   Egg Allergy : ❑ Rash ❑ Numbness/ Swelling ❑ Others:_____
   The name of vaccine(s)/ drug(s) and reaction(s) :_____
3. Has the recipient ever experienced any limb numbness or weakness, or allergic reactions after receiving seasonal influenza vaccination? ❑Yes ❑ No
4. Is the recipient suffering from any bleeding disorders or on blood thinners? ❑Yes ❑ No
5. (On vaccination day) Does the recipient has fever or feel sick? ❑Yes ❑ No

I_____ , the parent/ guardian of the vaccine recipient, declare the information given above is correct and I consent for him/ her to receive 2018/19 (Quadrivalent) influenza vaccination.

(or finger print if illiterate)

Signature of the parent/ guardian of recipient

Contact Telephone Number of parent/ guardian (must fill-in) :

Date:

職員專用欄

Prescription: Fluarix Tetra (Quadrivalent) 2018/19 strains 0.5ml ❑ 1 dose ❑ 2 doses

UCN: ❑OR ❑WL ❑BKT ❑JD ❑KF ❑TSW ❑CC Medical No. :

Doctor: Signature:

❑1st dose-Injection Record	Given by:	❑2nd dose-Injection Record	Given by:
Batch No.:	Date:	Batch No.:	Date: