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24 June 2014

Dear Doctor,

Incorporation of Varicella Vaccine into Childhood Immunisation Programme

We wish to inform you that varicella vaccine will be incorporated into the Hong Kong Childhood Immunisation Programme (HKCIP) starting 2 July 2014. Incorporation of varicella vaccine into the HKCIP was recommended by the Scientific Committee on Vaccine Preventable Diseases (SCVPD) under the Centre for Health Protection (CHP) of the Department of Health (DH). You may wish to refer to the recommendation from the SCVPD at the following link:

http://www.chp.gov.hk/files/pdf/recommendations_on_the_use_of_varicella_vaccine_in_cip_r.pdf

Children born on or after 1 January 2013 who reached one year old are eligible to receive the first dose of varicella vaccine together with other vaccines under the HKCIP at their scheduled vaccination appointments at Maternal and Child Health Centres (MCHCs). Currently children registered in MCHCs will have vaccination appointment at 12 months old for receiving Measles, Mumps and Rubella vaccine (MMR) as well as Pneumococcal Conjugate Vaccine (PCV); and at 18 months old for receiving Diphtheria, Tetanus, Acellular Pertussis and Inactivated Poliovirus vaccine (DTaP-IPV) at MCHCs under the HKCIP. Thus, when varicella vaccine is incorporated into HKCIP on 2 July 2014,

- Children who are born between 1 Jan and 30 June 2013 and have a scheduled vaccination appointment at MCHC between July 2014 and March 2015 will get the varicella vaccine on the same day for parents' convenience.
- Children born on or after 1 July 2013 will receive the varicella vaccine at the scheduled vaccination appointment when they reach 12 months old;

The second dose of varicella vaccine will be given by the School



Immunisation Teams (SIT) when these children who have received the first dose of vaccines reach primary one. The updated immunisation record DH6 (Rev July 2014) is enclosed for your reference. Currently there is no plan to conduct catch-up immunisation.

Two types of varicella-containing vaccines, the monovalent varicella vaccines (mVV) and combined measles, mumps, rubella and varicella vaccines (MMRV), are registered in Hong Kong for prevention of varicella infections. Both vaccines contain live attenuated virus derived from Oka strain of VZV. Since mVV and MMRV are both effective, either MMR and mVV or MMRV may be used for the two doses. However, in view of the increased risk of febrile seizures following the first dose of MMRV vaccination in young children, providers who are considering administering MMRV to children aged below 48 months should discuss the benefits and risks of both vaccination options with the parents or caregivers. In this regard, mVV will be provided to eligible children as first dose of varicella-containing vaccine at MCHC and MMRV will be offered by the SIT as second dose when these children reach primary one.

The DH will continue to monitor the disease burden of varicella and its related complications, to assess the impact of universal varicella vaccination. The reporting criteria for varicella is enclosed (Appendix II). Please notify varicella cases to the Central Notification Office (CENO) of CHP via fax (2477 2770) using the reporting form (Appendix III), phone (2477 2772) or CENO On-line (<http://ceno.chp.gov.hk/>). They are also available on CENO On-line website.

Latest information on the HKCIP can also be obtained from the Department's Family Health Service website (www.fhs.gov.hk) and the CHP website (www.chp.gov.hk). Parents may call the DH's hotline (2125 1133) for enquiries on varicella vaccination and the arrangement at MCHC.

Thank you again for your continuous support in combating infectious disease in Hong Kong.

Yours sincerely,



(Dr Yonnie LAM)

for Controller, Centre for Health Protection
Department of Health

HONG KONG CHILDHOOD IMMUNISATION PROGRAMME

香港兒童免疫接種計劃

AGE 年歲	IMMUNISATION RECOMMENDED 應接種之各種疫苗
Newborn 初生	B.C.G. Vaccine 卡介苗
	Hepatitis B Vaccine - First Dose 乙型肝炎疫苗 - 第一次
1 month 一個月	Hepatitis B Vaccine - Second Dose 乙型肝炎疫苗 - 第二次
2 months 兩個月	DTaP-IPV Vaccine - First Dose 白喉、破傷風、無細胞型百日咳及滅活小兒麻痺混合疫苗 - 第一次
	Pneumococcal Vaccine - First Dose 肺炎球菌疫苗 - 第一次
4 months 四個月	DTaP-IPV Vaccine - Second Dose 白喉、破傷風、無細胞型百日咳及滅活小兒麻痺混合疫苗 - 第二次
	Pneumococcal Vaccine - Second Dose 肺炎球菌疫苗 - 第二次
6 months 六個月	DTaP-IPV Vaccine - Third Dose 白喉、破傷風、無細胞型百日咳及滅活小兒麻痺混合疫苗 - 第三次
	Pneumococcal Vaccine - Third Dose 肺炎球菌疫苗 - 第三次
	Hepatitis B Vaccine - Third Dose 乙型肝炎疫苗 - 第三次
1 year 一歲	MMR Vaccine [Measles, Mumps & Rubella] - First Dose 麻疹、流行性腮腺炎及德國麻疹混合疫苗 - 第一次
	Pneumococcal Vaccine - Booster Dose 肺炎球菌疫苗 - 加強劑
	Varicella Vaccine - First Dose* 水痘疫苗 - 第一次*
1½ years 一歲半	DTaP-IPV Vaccine - Booster Dose 白喉、破傷風、無細胞型百日咳及滅活小兒麻痺混合疫苗 - 加強劑
Primary 1 小一	MMRV Vaccine [Measles, Mumps, Rubella & Varicella] - Second Dose* 麻疹、流行性腮腺炎、德國麻疹及水痘混合疫苗 - 第二次*
	DTaP-IPV Vaccine - Booster Dose 白喉、破傷風、無細胞型百日咳及滅活小兒麻痺混合疫苗 - 加強劑
Primary 6 小六	dTap-IPV Vaccine - Booster Dose 白喉、破傷風、無細胞型百日咳(減量)及滅活小兒麻痺混合疫苗 - 加強劑

DTaP-IPV Vaccine : Diphtheria, Tetanus, acellular Pertussis & Inactivated Poliovirus Vaccine

dTap-IPV Vaccine : Diphtheria, Tetanus, acellular Pertussis (reduced dose) & Inactivated Poliovirus Vaccine

*Varicella vaccines are incorporated into the Programme for children born on or after 1 Jan 2013. MMR vaccines would continue to be provided to children in Primary 1 who were born before this date.

*水痘疫苗已納入於2013年1月1日或以後出生兒童之計劃內，而麻疹、流行性腮腺炎及德國麻疹混合疫苗將會繼續提供給在此日期之前出生的小學一年級兒童。

Other vaccines not included in the above Programme are available in private clinics. These vaccines include influenza vaccine, Haemophilus influenzae type b vaccine, meningococcal vaccine, hepatitis A vaccine, Japanese encephalitis vaccine and combined vaccines which contain a combination of various vaccine components. Parents should seek advice from doctors before getting their children immunised.

除了上述疫苗外，個別私家醫生可以為兒童接種其他疫苗，例如流行性感胃疫苗、乙型流感嗜血桿菌疫苗、腦膜炎雙球菌疫苗、甲型肝炎疫苗、日本腦炎疫苗及一些包含多種疫苗成分的「多合一」疫苗。如家長希望為子女接種這些疫苗，應先請教醫生。

DEPARTMENT OF HEALTH THE GOVERNMENT OF THE HONG KONG SPECIAL ADMINISTRATIVE REGION 香港特別行政區政府衛生署 IMMUNISATION RECORD 免疫接種記錄

Name 姓名 _____

Date of Birth 出生日期 _____ Sex 性別 _____

Place of Birth 出生地點 ☐ Hong Kong 香港 ☐ Mainland China 中國內地
☐ Others (Please specify) 其他地區(請註明) _____

Parent's/Guardian's Name 父母/監護人姓名 _____

Case No. 編號 _____

MCH Centre 母嬰健康院 _____

This record should be presented when the child is to receive immunisation.

Please properly keep all the immunisation records because these may be required later as documentation of the vaccines received when your child enrolls at schools or emigrates abroad.

兒童在接種疫苗時須出示此記錄。

請妥善保存所有免疫接種記錄咭或小冊子，因孩子日後升學或移民時，此等記錄可作為孩子曾接種過有關疫苗的證明。

Name 姓名：_____ Date of Birth 出生日期：_____

Place of Birth 出生地點： ☐ Hong Kong 香港 ☐ Mainland China 中國內地

☐ Others (Please specify) 其他地區 (請註明) _____

TYPE OF VACCINE 疫苗種類	DATE 日期	PLACE 地點	REMARKS 附註 [#]
B.C.G. VACCINE 卡介苗			
HEPATITIS B IMMUNOGLOBULIN 乙型肝炎免疫球蛋白	INDICATED/ NOT INDICATED 需要/ 不需要		
HEPATITIS B VACCINE 乙型肝炎疫苗	FIRST DOSE 第一次		
	SECOND DOSE 第二次		
	THIRD DOSE 第三次		
DTaP-IPV VACCINE 白喉、破傷風、無細胞型 百日咳及滅活小兒麻痺 混合疫苗	FIRST DOSE 第一次		
	SECOND DOSE 第二次		
	THIRD DOSE 第三次		
	BOOSTER 加強劑		
	BOOSTER 加強劑		
dTap-IPV VACCINE 白喉、破傷風、無細胞型百日咳 (減量)及滅活小兒麻痺混合疫苗	BOOSTER 加強劑		
PNEUMOCOCCAL VACCINE 肺炎球菌疫苗	FIRST DOSE 第一次		
	SECOND DOSE 第二次		
	THIRD DOSE 第三次		
	BOOSTER 加強劑		
MMR VACCINE [Measles, Mumps & Rubella] 麻疹、流行性腮腺炎 及德國麻疹混合疫苗	FIRST DOSE 第一次		
VARICELLA VACCINE 水痘疫苗	FIRST DOSE 第一次		
MMRV VACCINE [Measles, Mumps, Rubella & Varicella] 麻疹、流行性腮腺炎、德國麻疹 及水痘混合疫苗			
OTHERS 其他			

DTaP-IPV Vaccine : Diphtheria, Tetanus, acellular Pertussis & Inactivated Poliovirus Vaccine

dTap-IPV Vaccine : Diphtheria, Tetanus, acellular Pertussis (reduced dose) & Inactivated Poliovirus Vaccine

[#] If the child has history of infection of the vaccine component or adverse events after immunisation, please mention in this column.

如兒童曾受疫苗成分感染或接種疫苗後出現不良反應，請在此註明。

Chickenpox

(Last updated on 3 June 2013)

Description

An illness with acute onset of diffuse (generalized) papulovesicular rash without other apparent cause. In vaccinated persons who develop chickenpox more than 42 days after vaccination (breakthrough disease), the disease is usually mild with fewer than 50 skin lesions and shorter duration of illness. The rash may also be atypical in appearance (maculopapular with few or no vesicles).

Laboratory criteria

Any one of the following:

- Isolation of varicella zoster virus from a clinical specimen
- Demonstration of four-fold or greater rise in antibody titre
- Demonstration of viral antigen in vesicular scrapings using fluorescent-antibody staining
- Positive PCR for varicella zoster virus in clinical specimen

Confirmed case

A clinically compatible illness that is **EITHER**

- Laboratory confirmed; **OR**
- Epidemiologically linked to a confirmed case

Probable case

A case that meets the typical clinical description, is not laboratory confirmed and is not epidemiologically linked to a confirmed case; **OR**

A case with atypical clinical presentation, who has history of chickenpox vaccination more than 42 days before onset, and is **EITHER**

- Diagnosed as chickenpox by a clinician without laboratory confirmation; **OR**
- Epidemiologically linked to another probable case.

PREVENTION AND CONTROL OF DISEASE ORDINANCE

(Cap. 599)

Notification of Infectious Diseases other than Tuberculosis

Particulars of Infected Person

Name in English:	Name in Chinese:	Age / Sex:	I.D. Card / Passport No.:
Residential address:			Telephone No. (Home):
Name and address of workplace / school:			(Mobile):
Job title / Class attended:			(Office / school / others):
Hospital / Clinic sent to (if any):			Hospital / A&E No.:

Disease ["✓"] below Suspected / Confirmed on ____ / ____ / ____ (Date: dd/mm/yyyy)

<input type="checkbox"/> Acute poliomyelitis <input type="checkbox"/> Amoebic dysentery <input type="checkbox"/> Anthrax <input type="checkbox"/> Bacillary dysentery <input type="checkbox"/> Botulism <input type="checkbox"/> Chickenpox <input type="checkbox"/> Chikungunya fever <input type="checkbox"/> Cholera <input type="checkbox"/> Community-associated methicillin-resistant <i>Staphylococcus aureus</i> infection <input type="checkbox"/> Creutzfeldt-Jakob disease <input type="checkbox"/> Dengue fever <input type="checkbox"/> Diphtheria <input type="checkbox"/> Enterovirus 71 infection <input type="checkbox"/> Food poisoning Number of persons known to be affected: ____ Place and district of consumption (e.g. "XX Restaurant in Mongkok"): _____ _____ _____ _____ Date of consumption: ____	<input type="checkbox"/> <i>Haemophilus influenzae</i> type b infection (invasive) <input type="checkbox"/> Hantavirus infection <input type="checkbox"/> Japanese encephalitis <input type="checkbox"/> Legionnaires' disease <input type="checkbox"/> Leprosy <input type="checkbox"/> Leptospirosis <input type="checkbox"/> Listeriosis <input type="checkbox"/> Malaria <input type="checkbox"/> Measles <input type="checkbox"/> Meningococcal infection (invasive) <input type="checkbox"/> Middle East Respiratory Syndrome <input type="checkbox"/> Mumps <input type="checkbox"/> Novel influenza A infection <input type="checkbox"/> Paratyphoid fever <input type="checkbox"/> Plague <input type="checkbox"/> Psittacosis <input type="checkbox"/> Q fever <input type="checkbox"/> Rabies <input type="checkbox"/> Relapsing fever	<input type="checkbox"/> Rubella and congenital rubella syndrome <input type="checkbox"/> Scarlet fever <input type="checkbox"/> Severe Acute Respiratory Syndrome <input type="checkbox"/> Shiga toxin-producing <i>Escherichia coli</i> infection <input type="checkbox"/> Smallpox <input type="checkbox"/> <i>Streptococcus suis</i> infection <input type="checkbox"/> Tetanus <input type="checkbox"/> Typhoid fever <input type="checkbox"/> Typhus and other rickettsial diseases <input type="checkbox"/> Viral haemorrhagic fever <input type="checkbox"/> Viral hepatitis <input type="checkbox"/> West Nile Virus Infection <input type="checkbox"/> Whooping cough <input type="checkbox"/> Yellow fever
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Notified under the Prevention and Control of Disease Regulation by

Dr. _____ of _____ Hospital / Clinic / Private Practice
(Full Name in BLOCK Letters)

_____ Ward / Unit / Specialty on ____ / ____ / ____ (Date: dd/mm/yyyy)

Telephone No.: _____ Fax No.: _____
(Signature)

Remarks: