

- ☐ A certificate issued by a Registered Medical Practitioner that **my child / ward *** is eligible for subsidised Vaccination
- ☐ A certificate issued by the person-in-charge of a designated institution serving persons with intellectual disability that my child / ward is a user of the institution

(Please provide a copy of the aforesaid document except the electronic version of Registration Card for People with Disability)

☐ **I am / My child is / My ward is***

- ☐ A recipient of the Social Welfare Department's Disability Allowance
(Please provide a copy of the disability allowance approval letter issued by the Social Welfare Department of the Government)
- ☐ A recipient of standard rate of "100% disabled" or "requiring constant attendance" under the "Comprehensive Social Security Assistance" ("CSSA") Scheme of the Social Welfare Department and is aged 18 to under 50
(Please provide a copy of documentary proof and sign a self-declaration form provided by the Private Doctor)

☐ **I am** aged 18 to under 50, and is certified by the Private Doctor as a person with any of the following specified chronic medical conditions[%]:

Confirmation of specified chronic medical conditions below by the Private Doctor

(Please also put a "✓" in the box concerned)[%]:

(Private Doctor's Signature)

[%] Specified chronic medical conditions comprise:

- ☐ Chronic cardiovascular (except hypertension without complication), lung, liver or kidney diseases;
- ☐ Metabolic diseases including diabetes mellitus or obesity (Body Mass Index 30 or above);
- ☐ Immunocompromised states related to weakened immune system due to conditions such as asplenia, Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome or cancer/ steroid treatment; and
- ☐ Chronic neurological conditions that can compromise respiratory functions or the handling of respiratory secretions or increase the risk for aspiration, or those who lack the ability to take care of themselves.

Remarks: _____

Persons aged 50 years and above

☐ **I am** aged 50 and above

Pneumococcal Vaccination

☐ **I am** at the age of 65 or above

- ☐ For Pneumococcal Vaccination, certified by the Private Doctor as an elderly person with any of the following high-risk conditions[#]:

Confirmation of high-risk conditions by the Private Doctor #: _____

(Private Doctor's Signature)

[#]For Pneumococcal Vaccination, high-risk conditions include:

- History of invasive pneumococcal disease, cerebrospinal fluid leakage or use of cochlear implant;
- Chronic cardiovascular (except hypertension without complication), lung, liver or kidney diseases;
- Metabolic diseases including diabetes mellitus or obesity (Body Mass Index 30 or above);
- Immunocompromised states related to weakened immune system due to conditions such as asplenia, Human Immunodeficiency Virus/ Acquired Immune Deficiency Syndrome or cancer/ steroid treatment; and
- Chronic neurological conditions that can compromise respiratory functions or the handling of respiratory secretions or increase the risk for aspiration, or those who lack the ability to take care of themselves.

4. eHealth REGISTRATION

- ☐ Vaccine recipient has already registered eHealth.
- ☐ Vaccine recipient has not registered or is unsure of his or her eHealth registration status. (Please fill in Part IV)

Part III [Consent]

☐ **CONSENT**

I have read / been informed and fully understood my obligation and liability under this consent form (including the Undertakings and Declarations) and the Statement of Purpose of Collection of Personal Data, and AGREE for myself/ my child/ ward* to receive the Seasonal Influenza Vaccine/ Pneumococcal Vaccine.

Signature of Vaccine Recipient/ Parents/ Guardian*:
(or finger print if illiterate@):

Relationship with Vaccine Recipient (If applicable):
☐ Father ☐ Mother ☐ Guardian

Name of Vaccine Recipient/ Parents/ Guardian*:

Contact Telephone No.:

Date of Signature:

@Witness shall complete the following if the vaccine recipient has mental capacity but is illiterate:

This document has been read and explained to the vaccine recipient in my presence.

Signature of Witness:

Name of Witness:

Hong Kong Identity Card No.
(only the alphabet and the first three digits are required)

						X	X	X	(X)
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Contact Telephone No.:

Date of Signature:

Part IV 【Consent to Register eHealth】		
<p>The following part is applicable to a person who has not registered with eHealth, or is unsure of his or her eHealth registration status</p> <p>eHealth registration is a prerequisite for all vaccine recipients aged 18 or above</p> <p>To be completed and signed by vaccine recipient <u>aged 18 or above</u></p> <p><input type="checkbox"/> I have read and understood the “Participant Information Notice” and “Personal Information Collection Statement” of eHealth and I AGREE to register with eHealth, which enables authorised healthcare providers to obtain and share my eHealth records for healthcare purposes.</p>		
Signature of Vaccine Recipient:	Mobile Number for receiving system notifications (with prefix 4/ 5/ 6/ 7/ 8/ 9):	Date of Signature:
<p>To be completed and signed by vaccine recipient <u>between the age of 16 and less than 18 years</u></p> <p><input type="checkbox"/> I agree I have read and understood the “Participant Information Notice” and “Personal Information Collection Statement” of eHealth and I AGREE to register with eHealth, which enables authorised healthcare providers to obtain and share my eHealth records for healthcare purposes.</p> <p><input type="checkbox"/> I disagree I have read and understood the “Participant Information Notice” and “Personal Information Collection Statement” of eHealth and I DISAGREE to register with eHealth.</p>		
Signature of Vaccine Recipient:	Mobile Number for receiving system notifications (with prefix 4/ 5/ 6/ 7/ 8/ 9):	Date of Signature:
<p>To be completed and signed by the Substitute Decision Maker (e.g. parent or guardian)</p> <p>(Only applicable to vaccine recipient aged under 16, or aged 16 or above but incapable of giving consent. eHealth registration is a prerequisite for all recipients aged 18 or above, or else they are not eligible for the vaccine.)</p> <p><input type="checkbox"/> I agree I have read and understood the “Participant Information Notice” and “Personal Information Collection Statement” of eHealth and on behalf of the healthcare recipient (HCR) AGREE to register with eHealth, which enables authorised healthcare providers to obtain and share the HCR’s eHealth records for healthcare purposes.</p> <p><input type="checkbox"/> I disagree I have read and understood the “Participant Information Notice” and “Personal Information Collection Statement” of eHealth and on behalf of the healthcare recipient (HCR) DISAGREE to register with eHealth.</p>		
Substitute Decision Maker's Surname in English:	Substitute Decision Maker's First Name in English:	Substitute Decision Maker's Mobile Number (with prefix 4/ 5/ 6/ 7/ 8/ 9):
Substitute Decision Maker's HK Identity Card No.:	For non HK Identity Card holder, please fill in information of other identity document	
	Document Type:	Document No.:
<p>Relationship with Vaccine Recipient:</p> <p><input type="checkbox"/> Vaccine recipient aged under 16 Parents/ Family Member/ Residing Person/ Guardian appointed under Guardianship of Minors Ordinance/ Person appointed by court *</p> <p><input type="checkbox"/> Vaccine recipient aged 16 or above but incapable of giving consent Family Member/ Residing Person/ Guardian appointed under Mental Health Ordinance/ Director of Social Welfare appointed under Mental Health Ordinance/ Person appointed by court *</p>		
Signature of Substitute Decision Maker:		Date of Signature:

Part V – To be filled in by Private Doctor providing the vaccination	
<input type="checkbox"/> Vaccination was provided to the vaccine recipient	
Name of Private Doctor:	
Private Doctor's Signature:	
Date of Vaccination:	
Place of Vaccination:	
Transaction No. (One transaction number only):	

DH_VSS (09/2025)

Vaccination Subsidy Scheme - Consent Information

Points to Note

- Please complete in BLOCK LETTERS using black or blue ball pen and put “✓” into the appropriate box(es) and * delete as appropriate.
- Vaccine recipient who is aged 18 or above with mental capacity may give consent by inserting his/her Hong Kong Identity Card to the Smart ID Card Reader provided by the Government to the Private Doctor's Clinic to read the card face data to replace the signing of the paper consent form (that is, eConsent).
- Part II (VACCINE RECIPIENT INFORMATION) and Part III (CONSENT) shall be completed and signed by a parent or guardian of the vaccine recipient if the vaccine recipient is aged below 18 or aged 18 or above but incapable of giving consent. Please read the information at <https://www.chp.gov.hk/en/features/17980.html> before you sign this form.
- Part IV (CONSENT TO REGISTER eHealth) shall be completed and signed by Substitute Decision Maker if the vaccine recipient is aged below 16 or aged 16 or above but incapable of giving consent. Please read the information on eHealth including the Participant Information Notice and Personal Information Collection Statement carefully.
- If two vaccines are given in the same visit, only one consent form is required. Otherwise, two separate consent forms must be filled out.
- If there is any inconsistency or ambiguity between the English version and the Chinese version, the English version shall prevail.
- **Interpretation:**
 - “Government” means the Government of the Hong Kong Special Administrative Region of the People's Republic of China.
 - “Private Doctor” means in respect of Vaccination Subsidy Scheme, the Registered Medical Practitioner whose application to enrol in the Scheme has been accepted by the Government.
 - “Registered Medical Practitioner” has the meaning given to it in Medical Registration Ordinance (Cap. 161).
 - “Substitute Decision Maker” has the meaning given to it in Electronic Health System Ordinance (Cap. 625).
 - “Vaccination” means in relation to a Vaccine in Part I above, the administration of such Vaccine to a vaccine recipient during the Vaccination Period.
 - “Vaccination Subsidy Scheme” means a scheme that provides subsidised seasonal influenza vaccination and pneumococcal vaccination to eligible Hong Kong residents through the participation of Private Doctors.

Undertakings and Declarations

1. I declare the information provided in this form is correct. I declare the information provided by me to the Government is up-to-date, true, accurate and complete in all respects at the time of provision.
2. I agree to provide my / my child / ward's personal data in this form and any information related to this consultation for the use by the Government for the purposes as set out in the “Statement of Purposes of Collection of Personal Data”. I hereby give consent to the Private Doctor to transfer and release my / my child / ward's personal data and any information related to this consultation to the Government, its agents, or other persons authorised by the Government. I note that the Government may contact me to verify whether I / my child / my ward have / has received vaccination by using the Government subsidy.
3. For vaccine recipient who is a Smart Identity Card holder: I hereby authorise the doctor to read my / my child's / my ward's personal data (limited to Hong Kong Identity Card No., Name (in English and Chinese), date of birth and date of issue of Hong Kong Identity Card) stored in the chip embodied in my / my child's / my ward's Smart Identity Card for the use by the Government for the purposes as set out in the “Statement of Purpose of Collection of Personal Data”.
4. This consent form shall be governed by and construed in accordance with the laws of the Hong Kong Special Administrative Region and I and the Government shall irrevocably submit to the exclusive jurisdiction of the courts of the Hong Kong Special Administrative Region.
5. I have read this consent form carefully and fully understood my obligations and liability under this consent form.

Statement of Purposes of Collection of Personal Data

Purposes of Collection

1. The personal data provided will be used by the Government for one or more of the following purposes:
 - (a) eHealth or eHealth System (Subsidies) (as the case may be) registration, payment of subsidy, and the administration, monitoring, auditing and evaluation of the Vaccination Subsidy Scheme, including but not limited to a verification procedure by electronic means with the data kept by the Government, processing of subsidy payment, providing necessary health care services to vaccine recipients and investigation of incidents and complaints;
 - (b) enhancing or facilitating the implementation of Government programmes which promote primary care, including but not limited to direct contact by the Government or its agents for engagement of healthcare activities and education;
 - (c) statistical, scheme monitoring, evaluation and research purposes;
 - (d) receiving vaccination information provided by the Government; and
 - (e) any other legitimate purposes as may be required, authorised or permitted by law.
2. The vaccination record made for the purpose of this consultation will be accessible by health care personnel in the public and private sectors for the purpose of determining and providing necessary health care service to the recipient.
3. The Government may disclose personal data and records of you / your child / your ward to other Government bureaux / departments concerned, or obtain such personal data or records from Government bureaux / departments concerned, for the purpose of verifying your eligibility under the Vaccination Subsidy Scheme.
4. The provision of personal data is voluntary. However, if you do not provide sufficient information, you may not be able to receive the subsidised vaccination.

Classes of Transferees

5. The personal data will be transferred to and used by the authorised user(s) or professional parties in the health field which are directly involved in the Vaccination Subsidy Scheme including but not limited to:
 - (a) Private Doctors and individuals authorised by the Private Doctors, as a clinic administrator, to access and use the IT platform;
 - (b) Primary Healthcare Commission (“PHCC”) and the operators appointed by PHCC;
 - (c) the Medical Council of Hong Kong, Dental Council of Hong Kong, Nursing Council of Hong Kong, Midwives Council of Hong Kong, Supplementary Medical Professional Council and five Boards set up under the Council (i.e. Medical Laboratory Technologists Board, Occupational Therapists Board, Physiotherapists Board, Radiographers Board and Optometrists Board), Chiropractors Council, Council on Human Reproductive Technology, Human Organ Transplant Board, Pharmacy and Poisons Board and Radiation Board and its agents;
 - (d) the Hospital Authority and its agents; and
 - (e) the Government's agents;
 for the purpose set out in Clause 1 above.

Access to Personal Data

6. You have the right to request access to and correction of your personal data under sections 18 and 22 and principle 6, schedule 1 to the Personal Data (Privacy) Ordinance (Cap. 486). A reasonable fee may be charged by the Government for processing any data access and/or correction request.

Enquiries

7. Enquiries concerning the personal data provided, including making data access and correction request, should be addressed to:
 Executive Officer (Vaccination Subsidy Scheme) / Telephone No.: 2125 2125
 Address: 3/F, Two Harbourfront, 18-22 Tak Fung Street, Hung Hom, Kowloon

Electronic Health System (eHealth)

The Electronic Health System (eHealth) is a territory-wide, patient-oriented electronic sharing platform which enables authorised healthcare providing organisations in the public and private sectors to access and share participating patients' electronic health records (eHR) for healthcare purposes. After joining eHealth, the Hospital Authority (HA), the Department of Health (DH) and individual private healthcare providers authorised by you can access your eHR on a need-to-know basis in the course of providing healthcare to enable more timely diagnosis and treatment, and reduce duplicate diagnostic tests. Joining eHealth is voluntary and free of charge. You can withdraw from eHealth or revoke any sharing consent given to a healthcare provider (other than HA and DH) anytime. **Citizens who registered with eHealth can check their vaccination record via the eHealth App.**

Please scan the QR code below to read and understand “Participant Information Notice” and “Personal Information Collection Statement”.

Participant Information Notice



Personal Information Collection Statement



For enquiries about registration or other issues about eHealth, please contact Electronic Health Record Registration Office at 3467 6300. For more information about eHealth, please visit the website at www.ehealth.gov.hk.