To: PMVD, CHP	From:	_____ (Name of Schools)
Fax: **2320 8505**	Name:	_____ (Contact person)
	Tel:	_____
	Date:	_____

Please check with medical organisation and fax this form to the Programme Management & Vaccination Division of the Centre for Health Protection (Fax number: **2320 8505**) **within one working day after collection of consent forms**.

2025/26 Seasonal Influenza Vaccination (SIV) School Outreach Programme
Public-Private-Partnership (PPP) Outreach Team

Consent Forms Receipt Note

This is to acknowledge that the PPP Outreach Team under Dr._____ (Name of Doctor) of _____ (Organisation) has collected _____ (Quantity) Consent Forms from _____ (Name of School) on _____ (Date).

Signature of Collector and Organisation Chop of the PPP Outreach Team	**Signature of School Representative and School Chop**
Name of Collector of the PPP Outreach Team	**Name of School Representative**