衞生署
2025/26 季節性流感疫苗學校外展計劃
公私營合作外展隊
醫療廢物暫存轉交記錄

注意事項：

1. 此表格只適用於持牌醫療廢物收集商**未能於**到校疫苗接種活動後即時收集醫療廢物的情況下使用，醫療機構外展隊應保留此表格的正本及學校應保留此表格的副本。
2. 醫療廢棄物須妥善貯存於臨時貯存區，直到收集為止。詳情，請參閱學校指引第 4 部分。
3. 請學校職員與收集商核對利器收集箱數量及重量後，於醫療廢物運載記錄上簽署及蓋印作實。

甲、聯絡資料

1. 參與計劃醫生姓名： (中文／英文) _____ **2.** 服務提供者號碼： _____

3. 所屬醫療機構名稱： (中文／英文) _____

4. 學校名稱： (中文／英文) _____

5. 學校編號： _____ **6.** 轉交日期： _____

7. 預計利器收集箱收集日期: _____

乙、醫療廢物轉交詳情：

疫苗接種場次 *(只適用於小學及幼稚園/幼兒中心* *For Primary Schools and KG/CCC only)* (請在適當的位置加上“✓”號)	**利器收集箱 數量**
☐ 接種第一劑(第一天) ☐ 接種第一劑(第二天) (小學適用) ☐ 接種第二劑	_____個

丙、醫療機構及學校簽署及蓋印

由醫療機構職員填寫

簽署： _____

姓名： _____

職位： _____

電話： _____

醫療機構蓋印

由學校代表填寫

簽署： _____

姓名： _____

職位： _____

電話： _____

學校蓋印

Department of Health
2025/26 Seasonal Influenza Vaccination School Outreach Programme
Public-Private-Partnership Vaccination Teams
Clinical Waste Temporary Storage Handover Form

Notes:

1. This form is **only applicable** to the condition that same day collection by licensed clinical waste collector immediately after the activities **cannot be arranged**. Vaccination team shall keep original copy while school shall keep a copy of the completed form for their record.
2. Clinical waste should store properly in the temporary storage area, until collection by licensed clinical waste collectors. For more details, please refer to Schools' Guide part 4.
3. School staff please verify the number and weight of the sharps box(es), sign and stamp the clinical waste transport record for confirmation.

Part A: Contact Information

1. Name of Participating Doctor: _____
2. Service Provider ID: _____
3. Name of Medical Organisation: _____
4. Name of School: _____
5. School Code: _____
6. Date of Handover: _____
7. Estimated Sharps Containers Collection Date: _____

Part B: Details of Handover of Clinical Waste

Vaccination Activity *(For Primary Schools and KG/CCC only)* **(Please put a "✓" as appropriate)**	**No. of Sharps Box(es)**
☐First Dose (Day 1) ☐First Dose (Day 2) (For Primary Schools only) ☐Second Dose (Day 1)	_____unit(s)

Part C: Signature of Medical Organisation and School Representative

To be filled by staff of Medical Organisation

Signature: _____
Name: _____
Position: _____
Tel: _____

Chop

To be filled by School Representative

Signature _____
Name: _____
Position: _____
Tel: _____

Chop