



Saviour Lutheran School

2025-2026 Seasonal Influenza Vaccination for Parents

(Circular No.: E039/2025-2026)

Dear Parents/Guardians,

In order to facilitate prevention of seasonal influenza, the school has invited the United Christian Nethersole Community Health Service (UCNCHS) to conduct on-site seasonal influenza vaccination for parents. Details are as follows:

1. Injection date: 10th November (Monday)
2. Time: 9:30 a.m. (Please be punctual)
3. Vaccine: Fluarix Tetra, a quadrivalent influenza vaccine produced by GlaxoSmithKline (GSK) Germany, providing protection against four influenza virus strains
4. Fee: \$100 per person (Free of charge if eligible under Section B of the attached Adult Participant Consent Form)
5. Venue: School

Please note that this registration is for parents only. The seasonal influenza vaccine for students is pending notification from the Department of Health. Students who wish to register for vaccination should await future announcements.


Parents who wish to register for vaccination must first complete the Adult Participant Consent Form issued by the UCNCHS. If more than one parent participates, please photocopy the consent form or obtain additional copies from the school nurse. Parents who are eligible Category B applicants may receive government subsidy. An additional Vaccine Subsidy Consent Form from the Department of Health must be completed. This form will be distributed upon parents' response to this notice as needed.

Kindly complete the reply slip on or before 17th October, 2025 (Wed) and return the reply slip to class teachers.

For any enquiries, please contact the school nurses Ms. Kung (primary school) or Ms. Ching (secondary school) at 2729 3929.

Yours faithfully,




 Rev. Yeong Ling Wui
 Principal
 10th October, 2025

-----**Reply Slip**----- ✂

2025-2026 Seasonal Influenza Vaccination for Parents

Circular No. E039/2025-2026 (Please return to Ms. Wong at General Office)

To: Saviour Lutheran School

I am the parent of _____ (student name) of class _____,

do not wish to apply for the seasonal influenza vaccination

I

wish to apply for vaccination for the following family member(s):

1. ____ person(s) eligible for Influenza Vaccination Subsidy (free of charge)
2. ____ person(s) aged 18-49 (\$100 per person)

Parent's signature: _____

Date: _____ October, 2025



For Staff Use Only	
<input type="checkbox"/> Regular	<input type="checkbox"/> Subsidized
Tran. No.:	

INFLUENZA VACCINATION SERVICE

Adult Consent Form

FLUARIX TETRA • GlaxoSmithKline (GSK) •
Manufactured in Germany protects against:

1. an A/Victoria/ 4897/2022 (H1N1) pdm09-like virus;
2. an A/Croatia/ 10136RV/2023 (H3N2)-like virus;
3. a B/ Austria/ 1359417/2021 (B/Victoria lineage)-like virus;
4. a B/Phuket/ 3073/2013 (B/Yamagata lineage)-like virus

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

* For students over 18 currently studying in a secondary school in HK, please fill the "Parent/Guardian" consent form

(A) Recipient's Personal Details (as indicated on identity document)

Name:	(For Outreach events)
Age:	Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female
	Organization Name:

(B) Eligible Statement: Influenza Vaccination Subsidy (Please select mark a in the appropriate boxes below)

I am a HK resident and agree to/ have already registered the eHealth^ system and meet one of the following criteria:

- Aged 50 years old or above
- I am Pregnant**
- I am receiving Disability Allowance**/ a recipient of standard rate of "100% disabled" or "requiring constant attendance" under Comprehensive Social Security Assistance Scheme**

Aged 18 to 49 yrs old with any of the following Chronic Medical Problems: (No relevant proof is required, but the government will conduct checks and verifications later; the vaccinee must declare truthfully)

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

- Notes: 1. ** 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.
2. ^ According to Government's regulations, all eligible persons using the "Influenza Vaccination Subsidy" must first register for the Electronic Health Record Sharing System (eHealth) in order to receive the subsidy. Our organization will assist those who do not have an account with the enrollment process. Person who refuses to join eHealth will not be entitled to use the subsidy.

(C) Recipient's Health Record (Please select the most suitable answer and mark a in the appropriate boxes below)

1. Are you allergic to eggs? Or have you ever had allergy or other allergic 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): _____
2. Have you ever experienced any limb numbness or weakness, or allergic reactions after receiving influenza vaccination? Yes No
3. Are you suffering from any bleeding disorders or on blood thinners (anticoagulants)? Yes No
4. (On vaccination day) Are you having fever or feeling sick? Yes No

I declare that **the information (Part A,B,C) given above is correct** and I consent to receiving the 2025/26 inactivated influenza vaccination.

Signature of recipient: _____ (or finger print if illiterate)

Contact Telephone Number (must fill-in) : _____ Date: _____

For Staff Use Only	
Prescription : Fluarix Tetra 2025/26 strains 0.5ml x 1 dose	Intramuscular injection
Doctor: _____	Signature: _____
Batch No.: _____	<input type="checkbox"/> Lt. deltoid <input type="checkbox"/> Rt. deltoid <input type="checkbox"/> _____
Given by: _____	Date: _____