



「幼兒專責醫師制度計畫」同意書 “Project of Holistic Physicians for Young Children” Consent Form

您好：

恭喜您的孩子成為衛生福利部「幼兒專責醫師制度計畫」的專屬照護對象。

Dear Sir/Madam,

Congratulations on enrolling your child in 「Project of Holistic Physicians for Young Children」 in dedicated care.

「幼兒專責醫師」最重要的任務，是在您的同意下，透過專業、專人的健康管理，整合政府提供的各項幼兒疾病預防與健康促進業務，讓您的孩子得到適時且連續性的健康照護，包括未滿 3 歲幼兒之照護諮詢、健檢、疫苗、塗氟等各項保健時程關懷等；若有特殊醫療需求，將協助您的孩子轉介到相關專業的醫療院所，或必要時安排居家訪視。

The most important mission of 「holistic physicians for young children」 is to integrate the child disease prevention and health promotion services implemented by the government to provide catered individual medical care and health management, so that your child can receive timely and ongoing health care. The care services include consultation, health check, vaccination and fluoride application for children under 3 years old.

本計畫相關人員亦將秉持保密原則，妥善處理您和您的孩子的資料；您不需額外支出相關費用、也沒有購買額外自費產品的壓力(醫療院所得酌收掛號費，或政府尚未補助之自費疫苗費用另計)，即可得到更完整的醫療服務。

All personnel in this system are under obligation to keep patient information confidential. You and your child's information will be kept secure. You will receive comprehensive medical services without additional fees, and also have no pressure to purchase self-paid services (excluding registration fees or self-paid vaccine).

如您還有其他疑問，可向您的幼兒專責醫師溝通反映，或洽詢所在縣市衛生局。

If you have further questions, you may discuss with your 「holistic physicians for young children」 or Public Health Bureau in your city/county.

衛生福利部 關心您！

Best regards,

Ministry of Health and Welfare

您的幼兒專責醫師 Your holistic physicians: _____

所在院所 Hospital address: _____

聯絡電話 Contact phone number: _____

幼兒資料 Child information	姓名 Name		身分證字號 ID number		出生日期 Birth date	年 月 日 DD/MM/YYYY / / ※需未滿3歲 ※Must be under 3 years old
	性別 Gender		是否為多胞胎 Multiple birth	<input type="checkbox"/> 否 <input type="checkbox"/> 是，同胎次序：○1 ○2 ○3 <input type="checkbox"/> No <input type="checkbox"/> Yes, sequence of this birth: ○1 ○2 ○3		
家長資料 Parent Information	姓名 Name		身分證字號 ID number		關係 Relationship	<input type="checkbox"/> 母 Mother <input type="checkbox"/> 父 Father <input type="checkbox"/> (外)祖父母 Grandparent <input type="checkbox"/> 監護人(請說明)： Legal guardian(please specify):
	聯絡電話 Contact number		聯絡地址 Address			
簽名 Signature		年 月 日 DD/MM/YYYY / /				

※外籍人士請填寫居留證號碼。

※Foreigners please fill in your ARC number.

※本同意書限幼兒之直系親屬簽署，若為社會福利機構監護之幼兒，將委由該機構授權。

※This consent form can only be signed by the child's lineal ascendant. If the child is in protective custody in a social welfare institution, it can be authorized by the institution.

(請沿此虛線撕下，並轉交幼兒專責醫師)

(Please tear along the dashed line and submit it to the physician)

基本資料 Information		姓名 Name	身分證字號 ID number	因特殊原因 無法取得之說明 Specify if cannot obtain the information
幼兒 Child				
父母親 Parents	父親(□同家長資料) Father(□same with Parent information)			
	母親(□同家長資料) Mother(□same with Parent information)			