

To All Allergy Patients,

The medical staff at WashU Student Health Center – Danforth Campus is committed to providing you with the safest health care possible regarding your allergy injections. Our medical staff will administer your allergy injections while you are at the university under the following policy. Please review the policy carefully and ask our staff any questions you may have, to help you fully understand the necessary compliance.

Please **place your initials** next to each statement below to indicate that you have read and agree to the following policies in order to receive allergy injections at WashU Student Health Center – Danforth Campus:

\_\_\_\_\_ *I will receive my very first injection in my allergist’s office. I understand that I need to continue to receive my injections at home through the summer in order to start them again upon my return to WashU.*

\_\_\_\_\_ *I understand and accept that allergy injections are associated with some widely recognized risks that can range from mild to life threatening. In increasing severity, some possible risks include: local reactions – at the area around the site of the injection; generalized reactions – which occur rarely, but are the most significant because of the potential danger of progression to low blood pressure and death if not tolerated. All generalized reactions require immediate evaluation and medical intervention.*

\_\_\_\_\_ *I understand that in the case that I experience a generalized reaction, SHC medical staff may refer me to an outside allergist office for future allergy injections and I will be unable to receive allergy injections at WashU Student Health Center – Danforth Campus.*

\_\_\_\_\_ *I will meet with a primary care provider at WashU Student Health Center – Danforth Campus prior to receiving my first allergy injection there. This can be done on the same day as my first injection.*

\_\_\_\_\_ *I will carry an Epi-Pen at all times on the day that I receive my allergy injection. I will show it to the nurse prior to receiving my injection.* ***I understand that if I do not have the epi-pen with me, I will not receive the injection****.*

\_\_\_\_\_ *I will remain in the office for* ***30 minutes*** *following my allergy injection for observation*.

\_\_\_\_\_ *When allergy injection appointments are missed, it changes the dose and/or schedule, which can cause reactions and compromise the safety of your allergy injections. I understand that* ***missing more than three scheduled allergy injections in one calendar year will result in permanent referral to an outside allergist*** *and I will no longer be able to receive allergy injections at WashU Student Health Center – Danforth Campus.*

­­­­\_\_\_\_\_ *I understand that WashU Student Health Center – Danforth Campus does not ship my vials and it is my responsibility to pick them up and ship/transport them to my desired destination under the specified storage directions of manufacturer*.

\_\_\_\_\_ *I understand that WashU Student Health Center – Danforth Campus will bill my health insurance for allergy injections unless I request to self-pay.*

By signing this statement, I understand and agree to follow my prescribing physician’s allergy injection schedule and WashU Student Health Center – Danforth Campus’ policy as stated above. I understand the benefits and risks of allergy injections and wish to proceed with administration of allergy injections.

Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_