

Student Request to Receive Allergy Immunotherapy

I request to receive my allergy injections at the Wake Forest University Student Health Service and agree to the following:

1. I understand that the prescription and mixing of my serum, the content of my vials, the concentration of my serum and the dosage schedule are the responsibility of my allergist, Dr. _____. There is not an allergist on staff at WFU.
2. I understand that the serum vials must be hand delivered by me to the Student Health Service.
Allergy vials should not be mailed directly to the Student Health Service
3. I understand that I must request a copy of my injection record and vials to take to my allergist during holidays, breaks and other absences. I understand the importance of keeping my serum refrigerated in transit. Allergy serum cannot be mailed out by the Student Health Service to me or my allergist at any time.
4. I understand that my Allergist must complete and submit the **Information for Allergy Clinic** and the **Physician Order for Allergy Immunotherapy** forms prior to my receiving allergy injections. These can be found on the Student Health webpage at shs.wfu.edu under the "forms" tab.
5. I understand that allergy injections are given by appointment only. Call 336-758-5218 to schedule during the regular academic year. Hours will change during the summer sessions.
6. I understand that there is a fee for allergy injections based on the number of injections that I receive.
 - a. 1 injection: \$10.00
 - b. 2 injections: \$11.00
 - c. 3 injections: \$12.00
 - d. 4 injections: \$13.00
 - e. 5 injections: \$14.00
7. I understand that I am **required to wait for no less than 20 minutes after my injection(s). I must check in with the allergy nurse prior to my leaving the Health Service.**
8. I understand that expired allergy serum will not be used and will be discarded.
9. I understand that certain medications for eye problems, headaches and blood pressure contain Beta Blockers which can increase sensitivity to allergens and potentiate anaphylaxis. I understand that if I am taking any new prescription or over the counter medications since my last visit to the Student Health Service, I must inform the nurse prior to receiving my injections.
10. I understand that I should report any reaction to my last allergy injection, any increase in allergy symptoms, or any change in my health status prior to receiving allergy injections. **If I am ill with fever, asthma, or respiratory difficulties, I will not be able to receive my injection until symptoms have improved.**
11. I understand that it is recommended that I not perform any strenuous exercise the 2 hours before or after my allergy injections.
12. In the event of a power outage or disaster that destroys my medication, I do not hold Student Health Service responsible.

In signing this statement, I acknowledge that I have fully read, understand and will abide by the information that it contains.

Student Name (print)

Student Signature

Date

Student ID#