

Dear Prospective Allergy Injection Patient:

Welcome to Wake Forest University,

The information you provided on your Health and Immunization forms indicated that you receive allergy injections. If you would like to continue your allergy injections here at Deacon Health, we will need the following forms to be completed:

- **Student Request to Receive Allergy Immunotherapy** (to be completed by student)
- **Physician Order for Allergy Immunotherapy** (to be completed by your physician)

Please bring these completed forms and your allergy serum to Deacon Health when you arrive on campus.

We will need at minimum 24 hours to review the orders prior to administering your injections.

Please note:

- Your first allergy injection must be given at your allergist's office before we can continue the therapy here at Deacon Health
- Venom immunotherapy, mixed vespoid and whole body extracts will not be administered by Deacon Health Staff.

Deacon Health is located in the lower level of the Reynolds Gym/Wellbeing Center.

We look forward to working with you!

Student Request to Receive Allergy Immunotherapy

I request to receive my allergy injections at the Wake Forest University Deacon Health 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 Deacon Health.
2. I understand that the serum vials must be hand delivered by me to Deacon Health. **Allergy vials should not be mailed directly to Deacon Health.**
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 Deacon Health to me or my allergist at any time.
4. I understand that my Allergist must complete and submit the **Physician Order for Allergy Immunotherapy** forms prior to my receiving allergy injections. These can be found on the Deacon Health webpage at <https://deaconhealth.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.
6. I understand that I must bring an EpiPen auto-injector with me to each injection appointment or I will not be able to receive the injection. I will obtain the EpiPen prescription from my allergist.
7. I understand that there is a fee for allergy injections based on the number of injections that I receive.
A. 1- 2 injections: \$15 B. 3 or more injections: \$20
8. **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 Deacon Health.**
9. I understand that expired allergy serum will not be used and will be discarded.
10. 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 Deacon Health, I must inform the nurse prior to receiving my injections.
11. I understand the venom, mixed vespid and whole body extracts will not be administered by Deacon Health Staff.
12. 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.**
13. I understand that it is recommended that I not perform any strenuous exercise the 2 hours before or after my allergy injections.
14. In the event of a power outage or disaster that destroys my medication, I do not hold Deacon Health responsible.
15. I understand that it is my allergist’s responsibility to complete all required paperwork. Failure to complete paperwork as requested will exclude me from allergy services at Deacon Health.

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

WFU Student ID