

Dear Allergy Injection Patient:

Our records indicate that you currently receive allergy injections. If you would like to continue your allergy immunotherapy at Deacon Health, you and your allergist's office must complete the following forms **before** you will be enrolled in our program:

- **Student Request to Receive Allergy Immunotherapy** - to be completed by you
- **Provider Order for Allergy Immunotherapy** - to be fully completed by your allergist's office

Please note:

- Your allergist must fill out our official order form completely. It must include all doses, the schedule for your shots, and instructions for what to do if you have a reaction. This helps us keep you safe and give consistent care.
- Your first allergy injection must be given at your allergist's office. After that we can continue the therapy here at Deacon Health
- Please have your allergist's office fax the completed forms to Deacon Health, **336-758-6054**.
- We require a minimum of 2 business days to review your documentation prior to administering any injection(s).

If you have any questions or concerns, please reach out to our office prior to your arrival.

Sincerely,
Deacon Health

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 prescribing 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 all shipments of serum vials to Deacon Health must be arranged in advance, with all required agreements completed prior to shipping.
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 ***Provider Order for Allergy Immunotherapy*** forms prior to my receiving allergy injections at Deacon Health. 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. (Service are limited during the Summer sessions)**
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), unless otherwise specified by my allergist. I must check in with the allergy nurse prior to leaving Deacon Health.**
9. I understand that expired allergy serum will not be used and will be discarded, unless otherwise indicated by my allergist.
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 clinical staff prior to receiving my injections.
11. 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, experiencing an asthma exacerbation, or respiratory difficulties, I will not be able to receive my injection until symptoms have improved.**
12. I understand that it is recommended that I not perform any strenuous exercise during the 2 hours before or after my allergy injections.
13. In the event of a power outage or disaster that destroys my medication, I do not hold Deacon Health responsible.
14. 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