Allergy Injections Agreement

Student Last Name: _____ First Name: _____

Date of birth: _____ SBU ID #: _____

Prior to the initiation of Allergy injections at SBU Health Services, please read the following and sign at the bottom if you agree with the terms and conditions of this service.

1. The student MUST be at maintenance and not be at increased risk for serious or anaphylactic reactions.

2. SBU has Basic Life Support available (O2, Benadryl, nebulizer, and Epinephrine). In the case of an anaphylactic reaction, 911 will be called and response times vary.

3. Health Services provider will review information and make determination if student is at maintenance and has no apparent increased risk of allergic reaction.

4. The Health Services medical manager (provider) has the right to refrain from initiating or may discontinue giving allergy injections to the student at any time the medical services manager/provider determines the student is at increased risk for anaphylactic reaction.

5. The Initial Allergy injection will be scheduled after receiving serum with orders and signed form (see below).

6. Completed and signed form should be mailed or faxed to Center for Student Wellbeing/Health Services. (See information below)

Medical Provider (Allergist):_____ Date:_____

Allergist Office Street Address: _____

Office City/State/Zip Code: _____

Office Phone: _____ Office Fax: _____

Center for Student Wellbeing
3261 West State Road
St. Bonaventure, New York 14778
Telephone (716) 375-2310
Fax (716) 375-7892