Allergy Injections Agreement

(to be completed by private allergist)

Student/Patient 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 patient 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 anaphylactic reaction, 911 will be called and response times vary.

3. Health Services provider will review information and make determination if patient 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 patient at any time the medical services manager/provider determines the patient 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, signed, and stamped form should be mailed or faxed to Center for Student Wellbeing/Health Services. (See information below).

Allergist Signature:_____Date:_____

Allergist Office Name and Street Address:_____

Office City/State/Zip Code: _____

Office Phone:_____Office Fax: _____

Provider Stamp:

Student Wellbeing - Health Services
3261 West State Road
St. Bonaventure, New York 14778
Telephone (716) 375-2310, Opt 1
Fax (716) 375-7892