St. Bonaventure University
Allergy Injection Agreement

Student Last Name: _____ First Name:_____
Date of birth: _____ Student ID: _____

Prior to the initiation of Allergy injections at SBU Health Services, please read the following and sign at the bottom if you are in agreement 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 Wellness/Health Services. **(See information below)**

_____ _____
Medical Provider (Allergist) Date

_____ _____
Address Office Phone

_____ _____
City and State Office Fax

_____
Zip code

Center for Student Wellness

St. Bonaventure University
122 Doyle Hall, PO Box 2469
St. Bonaventure, NY 14778
Phone: 716-375-2626 Fax: 716-375-7892

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