

REQUEST AND CONSENT FOR ADMINISTRATION OF ALLERGY IMMUNOTHERAPY

PATIENT INFORMATION (Please print or affix label):

Name _____

Student ID number _____

Date of Birth _____

Phone number _____

ORDERING PROVIDER INFORMATION (Please print):

Name _____ Phone number _____

Address _____ Fax number _____

City _____ State _____ Zip code _____

Office Hours

I request that the Missouri S&T Student Health administer Allergy Immunotherapy as prescribed by my referring allergist. I understand that S&T Student Health is administering this therapy as a service for me since my referring allergist is not on staff at S&T. I agree to abide by the schedule of shots as prescribed by my referring allergist. Injections are typically given every 1-4 weeks (or every 1-6 weeks for venom therapy). I understand that if immunotherapy injections are frequently missed, the risk for reaction increases; under such circumstances, immunotherapy injections may need to be discontinued at the discretion of the S&T medical staff until after consultation with my referring allergist.

I understand that allergy injections are associated with some widely recognized risks. In increasing severity, some possible reactions include: local reactions - at the area around the site of the injection; generalized reactions - which occur rarely, but are the most important because of the potential danger of progression to low blood pressure and death if not tolerated. All generalized reactions require immediate evaluation and medical intervention. Generalized reactions may be of one or more types:

- Hives/urticarial reactions
- Swelling/angioedema reactions
- Anaphylactic shock - including acute asthma, low blood pressure, unconsciousness and potentially death.

Generalized reactions are unpredictable and may occur with the first injection or after a long series of injections, with no previous warning. As a result, I agree to remain at S&T Student Health for a 30 minute observation period after each immunotherapy injection. If I cannot wait 30 minutes, I agree to notify the medical staff that I should not receive my immunotherapy injection. I also understand that if I leave before the appropriate observation time I will no longer be permitted to receive my allergy immunotherapy at S&T Student Health.

If I become pregnant while on immunotherapy, I will notify S&T Student Health medical staff immediately so that they can obtain and determine an appropriately revised dosage schedule from my referring allergist for the injections during pregnancy.

I agree to notify the S&T Student Health medical staff if I start any new prescription medication.

I also understand that:

- S&T Student Health is not my primary care provider in respect to this therapy.

- My medical management related to this therapy, therapeutic monitoring of the therapy and any necessary follow-up care is the responsibility of my referring allergist.
- If I have questions regarding the therapy or my medical condition related to the therapy, those questions should be directed to my referring allergist.
- S&T Student Health cannot guarantee the integrity of any extract that is transported to S&T Student Health by the patient.
- S&T Student Health will store my extract between appointments at between 1.7 and 7.8°C (35.0 and 46.0 °F) to reduce the rate of potency loss; however,
- I will not hold S&T Student Health responsible for the integrity of the extract in the event of a power failure, storage equipment failure, or other events that may corrupt the integrity of my extract.
- I further authorize the Providers at S&T Student Health to review my medical care, to recommend appropriate medical intervention to me and to discuss my medical care with my ordering provider and myself if, in the judgment of the S&T provider, this is necessary.
- I must bring my Epi-pen, if I have been prescribed one by my allergist, to every allergy injection session.
- S&T Student Health will charge a semester fee of \$45 to administer the allergy injections.
- If your allergist must be contacted for dosing changes/instructions due to non-compliance a \$5 charge will be placed on your account.
- Your allergy injections will not be administered if your allergist office is closed.
- If there is no contact with you for 6 months regarding your allergy injections any vials being stored at SHS will be discarded.

Patient Expectations:

- I should notify Missouri S& T staff if I am ill and have a fever.
- I should not exercise for 2 hours prior to and 2 hours after allergy injection.
- I should not scratch or rub the injection site.
- I should avoid or reduce environmental exposure to my allergen(s). Injections may need to be held or modified if I have recently increased runny eyes or nose, itchy eyes or nose, or am sneezing.
- If I have asthma- I should notify Missouri S&T staff I have used an inhaler in last 48 hours, missed daily activities due to asthma related problems, have used an inhaler 5-6 times in the last week, and/or complain of wheezing, shortness of breath, or chest tightness.
- I should take my antihistamine (allergy medication) as prescribed if ordered by my allergist.

This consent will be signed every fall and spring semester.

Signature of patient or authorized legal guardian

Date

Relationship to patient if signed by authorized representative

Signature of staff member who received form at Missouri S&T