Purdue Center for Healthy Living
Allergy Injection(s) Consent / Policy Form 2017-2018

Allergy Injections:
Purdue Center for Healthy Living will administer allergy shots to patients who have the Required Information for the Administration of Allergen Immunotherapy Form, from their doctor, a signed consent form and serum. Patients are seen for allergy injections only by appointment. Please see our policy regarding allergy shots below. If you do not wish to utilize our services for your allergy shots, there are private allergists in the Indianapolis area who will administer allergy serum.

1. The patient is responsible for providing the allergy serum.
2. Allergy serum must be accompanied by explicit directions for administration, late instructions, date of last injections, and a list of allergens in each bottle.
3. Each vial is to be labeled with the patient’s name and an expiration date.
4. The above criteria must be met prior to administration of allergy serum by our health services medical staff.
5. If you are so late for your shot that your allergist’s written instructions do not apply to the situation, it is your responsibility to call your allergist’s office and ask them to fax us instructions.
6. Visit www.purdue.edu/hr/chl for appointment times.
7. Injections are administered by a nurse. Disposable syringes and needles are provided.
8. You must report to the nurse any current illness or any prescription or non-prescription medications you are currently taking prior to receipt of an injection.
9. All reactions must be reported to the nurse before you receive your next injection. Local reactions consist of swelling and itching at the injection site. Please measure the size of the swelling (not the area of redness) and record the length of time the swelling lasts.
10. After the injection, the patient must wait at least 20 minutes. If your allergist’s instructions call for a longer wait then you must follow those instructions. The injection site must be checked. Inform the nurse immediately if you are having any itching, hives, coughing, sneezing, tightness in the chest or throat, wheezing, or difficulty breathing. If you have any of these symptoms after your departure call 911(cell) or 765-494-0111
13. The Center for Healthy Living provides storage for allergy serum. Reasonable care is taken to insure their safety. Refrigeration temperatures are monitored daily and if the temperature is out of range, it is addressed promptly and vaccines are moved to a different storage location, however, power outages or other malfunctions may cause temperatures to reach levels which may cause damage to the vaccine.
14. Please be advised that Health Services will not assume financial responsibility for damage caused by such unforeseeable occurrences. In the event of probable damage to your serum, you will be notified to obtain fresh serum from your providing physician.
15. If you discontinue the treatment or fail to appear for treatment for a period of ninety days, your vial will be discarded.
16. The Center for Healthy Living prohibits storage of expired medications. Therefore, unclaimed allergy extracts will be destroyed on the last day of the month during which they expire.

- See Reverse Side of Form for Signature Page -
Informed Consent for Administration of Allergen Immunotherapy

I have read or have had explained to me the information in the Allergy Injection Policy. I have had the opportunity to discuss these instructions and agree to follow them. I have read the information in this consent form and understand it. The opportunity has been provided for me to ask questions regarding the potential risks of immunotherapy, and these questions have been answered to my satisfaction.

I understand that consistent with the best medical practice will be carried out to protect me from adverse reactions to immunotherapy. I do hereby give consent for the patient designated below to be given immunotherapy (allergy injections) over an extended period of time and at specified intervals, as prescribed. I hereby give authorization by Purdue Center for Healthy Living, and staff, including authorization and consent for the treatment of any reactions that may occur as a result of an immunotherapy injection.

_____________________________ ___________________________________       ________________________________
Patient’s Signature                                                               Date

________________________________________________________________
Patient’s Printed Name

_____________________________ ________________________________
Parent’s/Legal Guardian’s Signature (if under 18 yrs.)                            Date
Immunotherapy Request Form

Request for Administration of Allergy Injections at an Outside Medical Facility

Patients, please complete this form if the allergy extract will be administered at a medical facility other than the office of the allergist-immunologist.

I have read and signed the Consent for Administration of Allergy Injections. However, I wish to have my injections administered at the medical facility designated below, and I request that my allergy serum, vial(s), along with instructions for administration of the injections, be forwarded to One to One Health medical facility designated below on June 30th, 2017. It is my responsibility to make certain that the facility and its staff are willing and able to provide allergy immunotherapy, and able to recognize and treat immediate or delayed adverse reactions that may result from the immunotherapy. I agree that I will not attempt to administer my extract injections to myself nor will I permit anyone who is not a licensed physician, or under the supervision of a licensed physician, to administer the extract injections. I further agree to notify this office if I transfer my immunotherapy extract vial(s) to any medical facility other than the one designated below. I understand that I may call this office at any time if questions or problems develop, and that I also may return at any time to this office for continued administration of my injections.

______________________________________________________________________________________
Printed Name of Immunotherapy Patient

______________________________________________________________________________________
Patient Signature (or Legal Guardian)

_______________________________________________________
Date Signed

NAME, ADDRESS, AND PHONE NUMBER OF THE PHYSICIAN WHO WILL SUPERVISE THE ADMINISTRATION OF THE ALLERGY INJECTIONS:

Physician Name: Stuart Isaacson, DO
Practice Name: Purdue Center for Healthy Living powered by One to One Health
Street Address: 1400 W. State Street West Lafayette, IN 47907
Phone/Fax Numbers: 765-494-0111/ 765-496-6656