

ALLERGY INJECTION(S) CONSENT/POLICY FORM

Allergy Injections:

One to One staff will administer allergy shots to patients who have completed all of the required documentation.

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 area who will administer allergy serum.

1. The patient is responsible for providing the allergy serum. ***If patient is just starting allergy injections or has initiated with a new allergist, they are required to receive the first two injections at their allergist's office.***
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. Injections are administered by medical personnel. Disposable syringes and needles are provided.
7. You must report any current illness or any prescription or non-prescription medications you are currently taking to medical personnel prior to receipt of an injection
8. All reactions must be reported to medical personnel 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.
9. After the injection, the patient must wait at least 30 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 medical personnel 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.
10. One to One clinic(s) may provide 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.
11. 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.
12. If you discontinue the treatment or fail to appear for treatment for a period of ninety days, your vial will be discarded.
13. One to One prohibits storage of expired medications. Therefore, unclaimed allergy extracts will be destroyed on the last day of the month during which they expire.

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

Patient Signature

Date

Patient Printed Name

Parent/Legal Guardian Signature (if under 18 yrs.)

Date

