Student Allergy Injection Information and Consent

You have requested to receive your allergy injections at the Xavier McGrath Health and Wellness Center (MHWC). You are asked to follow our procedures for safe allergy shot administration. Our procedures are in place for your safety. Please read the following information carefully. If you have any questions, please call our office at 513-745-3022 and ask to speak with a nurse.

1) You must have your prescribing allergist complete and sign the Allergy Immunotherapy Information form for prescribing physician and the Allergy Immunotherapy Check list.

2) The Allergy/ Immunotherapy check list must be completed by the allergist office with each new vial you bring to the MHWC.

Allergy injections are given by appointment only. If you fail to follow your allergy schedule on multiple occasions, we will stop providing the injections and you will be referred back to your allergist office.

Due to risks involved with allergy immunotherapy, you are required to wait for 30 minutes in our office after an allergy injection. You must check in with the nurse prior to departure. Injections are given when a physician or nurse practitioner is present in the office to manage reactions.

Local reactions may occur in patients receiving allergy injections. These symptoms include redness, slight itching and/or swelling around the injection site, bruising and/or tenderness at the injection site.

Another type of reaction for which we observe you is called a “systemic” reaction. These reactions may consist of any or all of the following symptoms: itchy eyes, nose, throat, and runny nose, nasal congestion, swelling of the face or lips, hives, and itching all over. Some patients may experience lightheadedness, faintness, nausea, difficulty breathing or chest pain.

If you experience a local reaction after you leave the facility, notify the nurse before you receive your next injection. If you experience a systemic reaction after you leave the medical facility, call 911 and go immediately to the nearest emergency room.

You should not receive an injection if you are ill, running a fever, experiencing active shortness of breath or wheezing or taking beta blockers.

I have read the above and agree to follow the procedures for safe administration. I request my allergy extracts be stored in the Health and Wellness Center refrigerator. I realize that this is at my risk and do not hold the Health Center responsible for my extracts. I agree to pick up my allergy extracts at scheduled university breaks as necessary. If I fail to do this and my injections are mailed to my allergist, I agree to pay the $25.00 fee for shipping and insurance.

Name (please print) ___________________________________________________________________

Signature____________________ Date__________

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