

LIPSCOMB UNIVERSITY HEALTH SERVICES

ALLERGY SHOT CONSENT FORM

Each person receiving allergy injections at Lipscomb University Health Center (LUHC) must answer these questions and sign their consent. If any information changes regarding their health information it is his/her responsibility to bring that to the attention of a staff member.

Name: _____ L Number: _____

Diagnosis: _____ When was your last shot? _____

Have you ever had a generalized reaction to an allergy shot such as hives or rashes? No _____ Yes _____

Have you ever had asthma or wheezing? No _____ Yes _____ (answer next 2 questions)

Been to the ER for this? _____ Been hospitalized for this? _____

What medications are you taking? (include prescribed and over the counter)

_____	_____
_____	_____
_____	_____

Allergy Injection Policy:

You must have received allergy shots before, had your first 2 injections at your allergist's office, and not have had more than 4 months layoff from immunotherapy (injections). LUHC will provide continuation of started immunotherapy with specific instructions from the prescribing provider and consent from the patient. Those with severe asthma or those on beta blockers cannot receive immunotherapy at LUHC. We will store the labeled antigen in the refrigerator at the LUHC. You are responsible for ordering new antigen and for arranging transfer of the sera when away from school.

Accompanying one's own clearly labeled immunotherapy vials, the client must bring a letter from his/her allergist with the following information:

- Your name and identifying information
- Physician's name, address, and phone number
- Instructions on administering the injections with specific vaccine, starting dose, target maintenance dose, and schedule.

LUHC will not give allergy shots if you have been sick in the past 3 days or are having an asthma exacerbation. You are responsible for coming to the clinic at regularly scheduled times and be there by 4:00 P.M. Appointments are necessary as there must be a provider and a nurse in the clinic for the injection and post-injection period. You must stay at the LUHC for 30 minutes after the shot(s) to check for a severe reaction. A nurse must check your arm before leaving. If a reaction occurs after leaving the clinic, you must report it at the next office visit.

I have reviewed the risks and benefits of allergy injections with my allergist. I understand the purpose and will follow-up with him/her at least once a year to evaluate the treatment of my allergic condition. I understand the Allergy Injection Policy at LUHC and will comply. I understand the risk of anaphylaxis and possible death with allergy injections. I consent to the risk and will allow LUHC staff to administer allergy injections to me when the appropriate conditions have been met.

Signature: _____ Date: _____