OFFICE OF STUDENT LIFE
STUDENT HEALTH CENTER
600 N. EAGLESON AVE.
BLOOMINGTON, IN 47405
812-855-7514 Fax: 812-856-8729

Student Request to Receive Allergy Immunotherapy

I request to receive my allergy injections at the Indiana University Student Health Center (SHC) and agree to the following:

1. I understand that the prescription and mixing of my serum, the content of my vials, the concentration of my serum, and the dosage schedule are the responsibility of my allergist, _____. There is not an allergist on staff at SHC.
2. I understand that the serum vials may be hand delivered by me or mailed to the SHC by my allergist's office. I understand that it is my responsibility to request my serum and a copy of my injection record to take to my allergist during holidays, breaks, and other absences and it is my responsibility to return these materials to SHC in order to continue to receive allergy injections. I understand the importance of keeping my serum refrigerated in transit.
3. The SHC will provide the service of storing allergy serum in a monitored refrigerator for patients between injections. The SHC is not liable for a compromise in the integrity of allergy serum due to handling before the SHC receives the medication, after it leaves our facility, or for loss or compromise of integrity due to power outage, storage equipment failure, or catastrophic event.
4. I understand that my Allergist must complete and fax to SHC the following forms prior to my receiving allergy injections (verbal orders are not accepted): These can be found at healthcenter.indiana.edu Click on Medical → Allergy Injections
   - **Referring Allergist Agreement**
   - **Allergen Immunotherapy Order Form**
5. I understand that I should report to the nurse any reaction to my last allergy injection, any increase in allergy symptoms, or any change in my health status prior to receiving any injections.
6. I understand that certain medications for eye problems, headaches, and blood pressure contain **Beta Blockers** which can increase sensitivity to allergens and potentiate anaphylaxis. I understand that if I am taking any new prescription or over the counter medications since my last visit to the SHC, I must inform the nurse prior to receiving any injections.
7. I understand that I am required to wait for 30 minutes at the SHC after my allergy injections.
8. I understand that I must schedule allergy appointments 24 hours in advance and if I am more than 6 minutes later for my appointment, I will not be able to be seen.
9. I understand that it is recommended that I not perform any strenuous exercise for two hours before and after my allergy injection.
10. I have been given the opportunity to ask questions and have all of my questions answered.

_____ _____
Student Name – Please Print Student Signature

_____ _____
Date University ID #