LAFAYETTE
BAILEY HEALTH CENTER

Allergy Clinic Student Agreement for Services

Allergy Extract Vial Labels
I understand that each vial must be labeled with: my first and last name; date of birth; content(s) of serum; concentration; expiration date.

Injection Schedule
I agree to abide by the injection schedule prescribed by my allergist. I understand that if I miss a scheduled appointment, it may result in a decreased dose administered at my next injection appointment and/or a delay in my receiving my allergy injections at Bailey Health Center.

I understand that allergy injections will not be administered if I have a fever, wheezing, or exacerbation of asthma and that I will need to reschedule my appointment. A physician or physician assistant must be on site at the time of your injection(s).

I understand that if I miss a scheduled allergy clinic appointment or cancel a scheduled allergy clinic appointment on the same day 3 times in a semester, I will be unable to receive allergy immunotherapy services at Bailey Health Center for the remainder of that semester.

Observation Period
I agree to remain at Bailey Health Center for 30 minutes after receiving an allergy injection. I will notify the nurse immediately if I experience itchy eyes, nose or throat; nasal congestion; itching; hives; shortness of breath; wheezing; flushing; sneezing; coughing; or any other symptoms that arise.

I agree to notify Bailey Health Center of any delayed reactions that I experience once I leave the clinic.

I understand that without exception, if I leave during the 30 minute observation period or before having my injections site(s) checked, I will no longer be permitted to receive my allergy immunotherapy at Bailey Health Center.

*I understand that there will be an annual charge of **$200 billed to my student account** to cover the cost of supplies.

I request that Bailey Health Center administer allergy immunotherapy as prescribed by my referring allergist. I understand and agree to all of the above and understand that Bailey Health Center is administering this therapy as a service to me because my referring allergist is not on staff at Bailey Health Center.

Patient Name (printed):_____ Date of Birth: _____

Patient or Authorized Guardian Signature:_____ Date: _____