SETON HALL UNIVERSITY HEALTH SERVICES (SHUHS)
TEL: 973-761-9175 FAX: 973-761-9193

Allergy Desensitization Injections Contract

Student Name: ______________________________ SHU ID # ____________________

Allergist Name: ____________________________ Phone: _______________________

Allergen(s) Vial(s) __________________________ Date of last injection:____________

I agree to

1. provide instructions for administration from my allergist.
2. provide a clinical summary from my allergist.
3. be compliant with the appointments and instructions from my allergist.
4. receive the first dose from each vial from my allergist.
5. store only the current vials being used in Health Services.
6. provide labeled serum(s) with my name and expiration date.
7. schedule my first appointment with a physician or nurse practitioner.
8. stay in SHUHS for observation at least 20 minutes following my injection (longer per my allergist's instructions).
9. notify my allergist and SHUHS of any adverse reactions which occur *after* leaving the office.
10. seek emergency care if I develop acute symptoms (i.e. shortness of breath, difficulty swallowing or symptoms of anaphylaxis) after my allergy injection.
11. be responsible for appropriate storage of the vials when they are not in SHUHS.

I understand that the provision of allergy injections will be terminated if I am not compliant with this policy. I understand my allergy serum will be disposed of when it reaches its' expiration date unless I have made other arrangements. All allergy serums will be picked up by me during summer and University breaks. I understand the Seton Hall University Health Services (SHUHS) is not responsible for lost or damaged serum.

I understand that SHUHS reserves the right to decline or discontinue allergy injection administration at any time. In the event that I cannot receive allergy injections at the SHUHS, I will be assisted in locating an appropriate alternative.

Patient Signature _________________________________ Date: ______________________

Allergy Injection Intake Form

To be completed before beginning allergy injections at Health Services (SHUHS).

1. When did you begin your allergy injections? ____________________________________

2. Are you getting injections containing insect venom?_______________________________

3. During what months are your allergy symptoms worse? ____________________________

4. Do you have any kind of heart disease or abnormality? ____Y ____N (If yes, please

   describe): ____

   ____

5. Have you ever had asthma or wheezing? _____Y _____N

6. How often do you currently experience allergy and/or asthma symptoms? ____________

7. Have you ever been admitted to the hospital for asthma or allergy treatment? ____Y ____N
   Number of admissions: ________

8. Have you ever gone to the Emergency Room for asthma or an allergic reaction?
   ____Y ____N Number of ER visits: ________ Dates: ________________________

9. List all allergy and asthma medications you have received in the past (include steroids/prednisone, inhaled medications, nebulizer treatments, injectables):
   ____

   ____

10. Have you ever had hives or rashes; difficulty breathing; swelling of the lips, tongue, throat; shock (anaphylaxis) or any other type of reaction to an allergy injection?
____Y ____N (If yes, please describe) ____

____

11. Are you taking any medications? (Include Epi Pen, prescribed, and over-the-counter medications.)

____Y ____N (If yes, please list) ____

Original: 7/99
Revised: 1/08
Reviewed: ____
Standard IV, “Quality of Care”