

To All Allergy Patients,

The medical staff at Habif Health and Wellness Center is committed to providing you with the safest health care possible regarding your allergy injections. Our medical staff will administer your allergy injections while you are at the university under the following policy. Please review the policy carefully and ask our staff any questions you may have, to help you fully understand the necessary compliance.

Please **place your initials** next to each statement below to indicate that you have read and agree to the following policies in order to receive allergy injections at Habif Health & Wellness Center:

\_\_\_\_\_ *I will receive my very first injection in my allergist’s office. I understand that I need to continue to receive my injections at home through the summer in order to start them again upon my return to Washington University.*

\_\_\_\_\_ *I will meet with a primary care provider at Habif Health & Wellness Center prior to receiving my first allergy injection there. This can be done on the same day as my first injection.*

\_\_\_\_\_ *I will carry an Epi-Pen at all times on the day that I receive my allergy injection. I will show it to the nurse prior to receiving my injection.* ***I understand that if I do not have the epi-pen with me, I will not receive the injection****.*

\_\_\_\_\_ *I will remain in the office for* ***30 minutes*** *following my allergy injection for observation*.

\_\_\_\_\_ *When allergy injection appointments are missed, it changes the dose and/or schedule, which can cause reactions and compromise the safety of your allergy injections. I understand that* ***missing more than three scheduled allergy injections in one calendar year will result in permanent referral to an outside allergist*** *and I will no longer be able to receive allergy injections at Habif Health & Wellness Center.*

­­­­\_\_\_\_\_ *I understand that Habif Health & Wellness Center does not ship my vials and it is my responsibility to pick them up and ship /transport them to my desired destination under the specified storage directions of manufacturer*.

\_\_\_\_\_ *I understand that Habif Health & Wellness Center will bill my health insurance for allergy injections unless I request to self-pay.*

By signing this statement, I understand and agree to follow my prescribing physician’s allergy injection schedule and the Habif Health & Wellness policy as stated above.

Print Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Student ID \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_