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Falcon Health Center Allergy Injection Student Agreement Form

1) Injection Schedule
   a) I agree to abide by the shot schedule prescribed by my allergist.
   b) I understand that if my allergy injections are administered late or are frequently missed, the risk for reactions increases. Under such circumstances, allergy injections may be rescheduled or discontinued at the discretion of the Falcon Health Center (FHC) medical staff in consultation with my allergist.
   c) I understand that FHC hours of operation for allergy injections are Monday through Friday, 8:00am to 4:00 pm. These hours are subject to change.
   d) Provider consents and patient agreements expire at the end of each academic year. Forms must be updated at the beginning of every fall semester.
2) Risks and Side Effects
   a) I understand that allergy injections are associated with some widely recognized risks. I verify that my allergist has discussed these risks with me. Possible reactions include local reactions at the area around the site of the injection and systemic reactions, which occur rarely but are of significant concern. Systemic reactions may include:
      (1) Itching of the throat, nose, eyes, palms
      (2) Hives
      (3) Wheezing
      (4) Chest Tightness
      (5) Facial Swelling
      (6) Anaphylactic shock including difficulty breathing, low blood pressure, dizziness, unconsciousness, and potentially death
   b) If your allergist advises that you be pretreated with an antihistamine, it is your responsibility to follow those instructions.
   c) Treatment of reactions will be according to your allergist's prescribed protocol.
3) Observation Period
   a) Systemic reactions are unpredictable and may occur with the first injection or after any subsequent injections with no previous warning. Due to the unpredictable nature of this, I agree to remain at FHC for a 20-to-30-minute observation period (as ordered by my allergist) after each injection, after which time I agree to have the injection site checked for localized reactions.
   b) I understand that if I leave before the appropriate wait time, I may no longer be permitted to receive my allergy injections at Falcon Health Center.

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4) New Information
   a) I agree to notify the FCH medical staff if I start any new prescription or non-prescription medications, particularly medication for high blood pressure, migraine headaches, or glaucoma.
   b) If I become pregnant during any period that I am receiving allergy injections, I will notify my allergist and the FHC medical staff immediately.
5) Falcon Health Center Roles
   a) Falcon Health Center will store my extracts between 3°C and 6°C to reduce the rate of potency loss. However, I will not hold FHC responsible for the integrity of the extract in the event of a power failure, storage equipment failure, or catastrophic event that may corrupt the integrity of the extract.
   b) At the end of each academic semester (Approximately end of December and end of May), all allergy extracts stored at Falcon Health Center will be inventoried. If my vials are expired, I give FHC the right to dispose of my serum according to the medication disposal policy. If I have not received allergy injections within the last four (4) months, FHC will either dispose of (if expired) or return my vials.
   c) I understand that FHC does not guarantee the integrity of any extract transported to FHC by the patient, family, or shipped directly to FHC by my allergist.
   d) I understand that FHC is not my primary care provider with respect to this therapy; and I agree that the medical management, therapeutic monitoring, and any necessary follow-up care of this therapy are the responsibilities of my allergist.
   e) If I have questions regarding this therapy or my medical condition related to this therapy, I understand they should be directed to my allergist.

I request that Falcon Health Center (FHC) administer allergy immunotherapy injections as prescribed by my allergist. I have read the above Student Agreement for Allergy Immunotherapy Administration. I understand that failure on my part to follow the terms of this agreement will result in discharge from FHC's Allergy Immunotherapy Clinic.

_____ _____

Patient Name (please print) Date of Birth

_____ _____

Patient or Authorized Guardian Signature Date

_____ _____

FHC Staff Signature Date