Allergy Clinic Student Agreement for Services

Student Health and Wellness, Allergy Clinic Role

I understand that the University of Virginia (UVA) Student Health and Wellness, Allergy Clinic does not initiate immunotherapy treatment and that my first injection must be received at my allergist's office.

I understand that UVA Student Health and Wellness, Allergy Clinic will store my allergy serum extract vials between 2°C and 8°C in a secure/locked environment and is not responsible for the viability of the extract in the event of any of the following: power failure, storage equipment failure, catastrophic event that may occur.

I understand that it is my responsibility to provide completed and signed documents including treatment orders from my allergist on UVA forms each academic year and/or as my treatment is changed by my allergist to UVA Student Health and Wellness, Allergy Clinic.

I understand that UVA Student Health and Wellness, Allergy Clinic will provide me an itemized statement for services rendered and that I am responsible for filing it with my insurance company.

Risks and Side Effects

I understand that allergy injections are associated with risk of possible local and/or systemic reactions which include but are not limited to: itching runny nose, shortness of breath, nasal congestion, wheezing, flushing, hives, coughing, and anaphylaxis.

If my allergist prescribes an epinephrine auto injector, antihistamine, and/or peak flow measurement, I agree to carry my epinephrine auto injector, take an antihistamine as instructed and/or perform peak flow before and after my injections(s) as prescribed by my allergist. I understand that I must avoid strenuous activity for two hours after receiving my allergy injection(s). I understand I may not receive allergy injections if I do not follow my allergist's instructions.

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.
I understand that UVA Student Health and Wellness, Allergy Clinic will not accept vials that are not completely labeled and that I am responsible for returning mislabeled vials to my allergist.

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 UVA Student Health and Wellness, Allergy Clinic.

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.

Observation Period

I agree to remain visible in the Allergy Clinic waiting area or other space as designated by clinic staff, for a 30-minute observation period 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 UVA Student Health and Wellness, Allergy Clinic 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 injection site(s) assessed by a nurse, I will no longer be permitted to receive my allergy immunotherapy at UVA Student Health and Wellness, Allergy Clinic.

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I request that the UVA Health and Wellness, Allergy Clinic administer allergy immunotherapy as prescribed by my referring allergist. I understand and agree to all of the above and understand that UVA Health and Wellness Services is administering this therapy as a service to me because my referring allergist is not on staff at UVA Student Health and Wellness.

Patient Name (printed):_____Date of Birth:_____

Patient or Authorized Guardian Signature:_____Date:_____

Patient label/Medicat #: