KENT STATE UNIVERSITY | University Health Services

Patient Agreement and Instruction Sheet for Allergy Injections

1. When requesting treatment, you must provide solutions and antigen instructions from your physician. Your name, DOB, vial identification and expiration date must be on each vial.

2. If the instructions from your allergist are unclear, we will request written clarification and you might have to wait or reschedule.

3. Injection charges will be billed to your insurance if applicable. Otherwise, payment is due at time of service.

4. Please make an appointment for each injection at least one day in advance of your appointment.

5. **YOU ARE REQUIRED TO REMAIN AT THE HEALTH CENTER FOR A MINIMUM OF 20 MINUTES (or longer if specified by your allergist) AFTER YOUR INJECTION.** You must have your arm checked by the nurse after the waiting period. If you notice any unusual reaction during your waiting period such as "hives", difficulty breathing or chest tightness, flushing, perspiration, nausea, dizziness, itching/swelling/unusual redness at the injection site, **REPORT TO THE NURSE IMMEDIATELY.**

6. You must receive injections as scheduled by your physician. If you are late, and don't follow the treatment schedule the dosage may have to be reduced and the benefit of the treatment might be compromised. We may be unable to continue giving your allergy injections at the Health Center if you:
   a. Fail to follow treatment schedule
   b. **Fail to remain for the 20-minute waiting period**
   c. Fail to have the injection site(s) checked following the waiting period

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I, _____, have read the above Allergy Treatment Procedure and understand that this is a protocol of Kent State University Health Services, and that I must abide and follow the procedures as noted above. I understand that failure on my part to follow this procedure will result in my not being able to receive allergy injections at KSU Health Services.

Signature _____

Kent State ID # _____

Signature of Registered Nurse _____

Date _____