HEALTH SERVICES
Student Services
SETON HALL UNIVERSITY
Phone: 973-761-9175 Fax: 973-761-9193

ALLERGY INJECTIONS CONTRACT

Student Name: _____ SHU ID #: _____

Allergist Name: _____ Allergist Phone: _____

Date of Last Injection: _____

I agree to:

- Provide instructions for administration from my allergist.
- Provide a clinical summary from my allergist.
- Be complaint with instructions from my allergist (includes appointment intervals, pre-medication).
- Receive the first dose from each vial from my allergist.
- Provide labeled serum(s) with my name and expiration date.
- Store current vials in Health Services.
- Notify Health Services if I need to reschedule or change my appointment.
- Stay in Health Services for observation at least 20 minutes following my injection (or longer per my allergist's instructions).
- Notify my allergist and Health Services of any adverse reactions which occur after leaving the office.
- Seek emergency care if I develop acute symptoms (i.e., shortness of breath, difficulty swallowing or symptoms of anaphylaxis).
- Pick up serum during summer and University breaks.
- Be responsible for appropriate storage of the vials when they are not in Health Services.

In addition:

- 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 the expiration date.
- I understand the Seton Hall University Health Services is not responsible for lost or damaged serum.
- I understand that Health Services reserves the right to decline or discontinue allergy injection administration at any time, If I cannot receive allergy injections at Health Services, I will be assisted in locating an alternative provider.

Patient Signature: _____ Date: _____

Review Signature: _____ Date: _____
(Seton Hall University staff review signature)