# DUKE STUDENT HEALTH CENTER

Patient Name: _____ Date: _____

DOB: _____ MR#: _____

**Duke Student Health Allergy Clinic (DSHAC)**
**Informed Consent to Receive Allergy Immunotherapy**

I request to receive my allergy immunotherapy at the Duke Student Health Allergy Clinic (DSHAC) and agree to the following:

1. I understand that the prescription and mixing of my extracts, the content of my vials, the concentration of my extracts, the dosage schedule and the administration of the initial immunotherapy injection are the responsibility of my private physician, Dr. _____, and I do not hold Duke Student Health responsible for these tasks. *The private medical provider cannot be someone with whom you have a significant emotional relationship (e.g. parent, sibling, or other relative).

2. I understand that extract vials must be hand delivered by me or sent via next day shipping services (**FedEx or UPS**) and **may not be mailed via US Postal Service** or directly forwarded to DSHAC. DSHAC is not responsible for breakage or loss of extracts. I understand that it is my responsibility to sign out my extracts and a copy of my injection record during holidays, breaks, and other absences and it is my responsibility to return these materials to DSHAC in order to continue to receive allergy shots. I understand that it is my responsibility to retrieve my extracts at the end of the academic year (if I am leaving campus) and DSHAC will not mail/forward extracts. ***Please clarify with your provider, the proper shipping and handling of your sera. Sera that has been frozen or heated will not provide effective immunotherapy**. *

3. I understand that my private physician must complete a *Request for Allergy Immunotherapy Initiated by Non-Student Health Services Physician* form prior to my receiving shots at DSHAC.

4. I understand that I must remain in view of the nurse for **30 minutes** after receiving any shots and may not leave the area during this period of nursing observation.

5. I understand that after the observation period, I must have the injection sites evaluated by a nurse before leaving the facility. If I leave without having the nurse check and record results, I may no longer receive allergy shots at DSHAC.

6. I understand that my prescribed allergy treatment must be fully compliant with the policies and procedures of Duke Student Health.

7. I understand that certain medications for eye problems, headaches and blood pressure contain beta blockers which can increase sensitivity to allergens and potentiate anaphylaxis. I understand that if I am taking any new prescription or over the counter medications since my last visit to the DSHAC, I must inform the nurse prior to receiving any injections.

8. I have been given the *Allergy Immunotherapy Instructions* sheet. I have read and understand this information detailed on the *Allergy Immunotherapy Instructions* sheet and I have been given the opportunity to ask questions and have all of my questions answered.

9. I understand that at any time the DSHAC may decline or withdraw my eligibility in participation in the DSHAC.

_____ _____
**Student Signature** **Date**

_____ _____
**Duke ID#** **Witness**