VSU ALLERGY SHOT ADMINISTRATION REQUEST FORM
Student Health Services Department
(Confidential Medical Document)

I. Patient Information

Students Full Name:_____
Date of Birth:_____
V Number:_____
Phone Number:_____
Residence Hall Name and Room Number:_____
Emergency Contact Name and Phone Number:_____
Student's Allergies/Diagnosis:_____
_____
_____

II. Allergist Instructions (Required Before Injections Begin)

This section must be completed by the prescribing allergist's office before allergy injections are given. An order with clear instructions must be submitted with this form. This form is for maintenance dose administration ONLY. ***VSU Student Health Services will NOT administer the first dose of a prescribed allergen.***

Provider Name:_____
Practice Name:_____
Practice Address:_____
Allergist's Office Phone Number:_____

- **Allergens to be Administered:**
  ☐ Vial #1: _____
  ☐ Vial #2: _____
  ☐ Vial #3: _____
- **Dilution Schedule:** Attach copy or describe below:
- **Maintenance Dose:** _____
- **Dosing Frequency:** _____
- **Pre-Medication Required?** ☐ Yes ☐ No
  If yes, list: _____
- **Special Instructions:**

Allergist's Signature and Title: _____**Date:** _____

III. Student Consent and Agreement

I understand that:

- Allergy shots carry a risk of severe allergic reactions, including anaphylaxis.
- I am responsible for bringing my vials to each appointment and ensuring they are stored properly.
- I must wait **30 minutes** after each injection in the clinic for observation.
- I will notify Student Health Services of any reactions experienced after leaving.
- If I receive injections elsewhere, I must inform Student Health before my next injection here.

I consent to receive allergy injections as prescribed by my allergist at the university Student Health Services clinic. I release the university and its staff from liability for reactions associated with the administration of allergy shots.

Student Signature: _____
Date: _____

IV. Administration Will be Documented in Electronic Record as per protocol

V. Emergency Protocol Confirmation

In case of an anaphylactic reaction:

- **Epinephrine Auto-Injector** (EpiPen) available on-site in clinic
- **Benedryl Administration, if ordered?**_____
- **Clinic Emergency Contact:** (804)524-5711
- **Call 9-911 if reaction occurs after injection or after clinic hours.**
- **Notify Allergist Office about reaction as soon as possible.**

Reviewed by Nurse/Provider: _____
Date: _____