Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Patient’s Net ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Consent for Allergy Injections**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, authorize the physicians of the John C. Longest Student Health Center (LSHC) and such assistants that may be selected by them to perform allergy injection(s) as prescribed by my allergy clinic (\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_). My prescribing allergy physician has explained the procedure necessary to treat my allergy/allergies and I understand it to be as follows:

· Allergy injection(s) are given at the recommended intervals as set forth by the prescribing physician/clinic. I understand there is the possibility of a local reaction at the site of the injection or a systemic reaction which in rare cases could result in death. I am aware the practice of medicine is not an exact science and I acknowledge no guarantees have been made to me about the results of any allergy injection(s).

**Administration of Allergy Extract at an Outside Clinic**

I have read (new patient)/re-read (established patient) the information about allergy injection(s) and agree I will NOT attempt to administer my extract to myself, nor will I permit anyone who is not a licensed physician (or under the supervision of a licensed physician) to administer my allergy extracts to myself or someone else.

**Facility Where Allergy Injections will be Administered:**

Mississippi State University

Longest Student Health Center Patient Signature Date

360 Hardy Rd.

Mississippi State, MS 39762

(t) 662-325-2431/325-7535

(f) 662-325-8888 Witness Signature Date

**Medical Director’s Acknowledgement of Allergy Injection**

The above-named patient wishes to receive his/her allergy injection(s) at MSU-Longest Student Health Center. The patient has read the information about allergy injection(s) and signed all necessary consent forms.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Medical Director at LSHC), have reviewed instructions provided to this clinic by the patient’s prescribing allergist/clinic and hereby give the above-named patient permission to receive his/her allergy injection(s) at LSHC under my supervision. As medical director, I acknowledge that the LSHC Shot Room has injectable epinephrine on-hand in the treatment area should anaphylaxis occur.

Medical Director’s Signature Date