STEPHEN F. AUSTIN STATE UNIVERSITY

ALLERGEN INJECTION CONSENT FORM

Please print this form and bring it to the Health Services Clinic after it has been completely filled out. This information is confidential and will not be released without the written consent of the applicant.

Name_____________________________ **Age**____ CID: ________________________________

Local Address ________________________________ **Home Address** _________________________

____ ______________________________________

Phone _____________________________________ **Phone** ________________________________

Name of person to be notified in case of emergency:____

Home phone______________________________ **Office Phone**____________________________

Prescribing Physician's Name/Address ____

____**Phone** _________________________

ANSWER THE FOLLOWING QUESTIONS AS COMPLETELY AS POSSIBLE:

Have you ever had any reaction to serum, blood, drugs or any medicine? Y____ N____

If yes, state which ____
What is your present state of health?___________________________________

Have you had any serious illnesses, diseases or hospitalizations?
Y ___ N ___ If yes, please explain____________________________________

I give permission to the Stephen F. Austin State University Health Services, to provide for such allergy injection and standard immunizations as needed or requested by me.

I understand that the University Health Clinic will allow me to keep my allergy extract in the clinic refrigerator as a courtesy and convenience to me and that it will be available to me only during regular clinic hours. The clinic will not be responsible for the loss of any kind including theft, accidental breakage, or damage from heat or cold. Extracts over one year old that are not being used will be discarded.

I certify that the foregoing information is true and complete to the best of my knowledge. I acknowledge the receipt of a copy of the allergen injection policy and agree to comply with the policy.

Patient's/Parent's Signature____________________________ Date________________
(Parent must sign if patient is under the age of 18)