St. Bonaventure University

Allergy Injections Consent

STUDENT LAST NAME: _____ ___ FIRST NAME: _____

Date of Birth: _____ SBU ID #: _____

Please read over this informed consent very carefully. Initial each item and then sign and write the date at the bottom. Then return the document to us using one of the methods below. ***Phone camera pictures are not accepted.***

_____ 1. Each case will be evaluated by the medical services manager. I realize this is not a guaranteed service and the **medical services manager reserves the right to refuse this service at any time, if it is deemed you (or your child) is at increased risk for a serious or anaphylactic reaction.** In the event that the service is discontinued the Health Services staff will help the student to find a local allergist or an allergist near the student's home for future services.

_____ 2. Your allergy serum(s) will be stored on-site in refrigeration units in Health Services; and it is my responsibility to transport serum to and from my allergist.

_____3. I agree to bring my own EpiPen to each injection visit. I understand that if I forget my EpiPen, I will be rescheduled for a visit at a later date.

_____ 4. I agree to remain on site for 30 minutes following the injection(s) or longer if deemed necessary.

_____ 5. In the event of a severe allergic or anaphylactic reaction, I understand that SBU has **Basic Life-Support** available (O2, Benadryl, nebulizer, and epinephrine). An ambulance will be called to transport me (your child) to the Olean General Hospital Emergency Department and response times vary.

Student signature: _____ Date: _____
(For students 18 yrs and older.)

Parent signature: _____ Date: _____
(For students 17 yrs and under.)

Please return this form by mail, fax, scan and email, or hand deliver (See below).

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