

Allergy Injection Policy

Student Health Center

Linden Hall
201 Mullica Hill Road
Glassboro, NJ 08028-1701

856-256-4333
856-256-4427 (fax)

Students receiving regular allergy injections may have them given by a Registered Nurse if the following conditions are met:

1. The Student must have a complete medical record on file in the Student Health Center (SHC). The student must sign permission for allergy injection and release of responsibility of liability in the event of a reaction. If under 18 years old, a parent or guardian must sign.
2. The student is responsible for supplying serum. Serum must be stored at the Student Health Center. **Serum must be clearly labeled and accompanied by completed Rowan University Student Health Allergy Injection Schedule and Allergen Immunotherapy Administration. The schedule must be written for the semester with dosage, site and frequency of injections. The RN has the right to refuse the injection schedule if it is not clear.** An expiration date must be on each vial. RNs cannot accept phone instructions. We will accept faxed instructions signed by the physician at 856-256-4427. Instructions and serum provided by an out-of-state physician must be approved by our Student Health Center physician.
3. The Student Health Center is not responsible for replacement of serum that is lost or damaged. Serum should not be sent directly to the Student Health Center. It is the student's responsibility to pick up all serum at the end of the school year.
4. **The student's first serum injection must be given in the allergist's office and documented (date, dosage, site, reaction and signature).** We cannot begin a new serum on any student. **The 1st dose of any NEW bottle or INCREASE in STRENGTH of bottle, must be given in the Allergist/MD office. If there is any significant Systemic Reaction, the student MUST RETURN to his/her allergist for revised dosing schedule.**
5. The nurse should be advised if the student is taking any medications, has cold or allergy symptoms, had a prolonged or delayed reaction to last injection or is pregnant.
6. **Allergist must complete the mandatory Rowan University SHC Allergy Schedule and Allergen Immunotherapy Administration forms. The allergist must sign both forms.**
7. An appointment must be made for a one time consultation with a RN at the beginning of each semester. Completed forms must be submitted with the allergy serum at the initial nurse consultation prior to receiving injections. This will include reviewing the schedule with the patient and our policies regarding allergy injections. Schedules must be approved by RN, one time allergy injection fee must be paid, and consent for administration and fees must be signed by student prior to first allergy injection.

8. All allergy injections are given during physician's hours Monday-Friday. Please call ahead to confirm hours and make an appointment with the RN.
9. We will not be responsible to fax any incomplete documents to your physician. The schedule will be returned to student and asked to be completed properly before administration may begin in our office. **If faxing has to be done due to time constraints or distance of student from physician, a fee will be charged.**
10. The Student Health Center charges a one-time fee per semester for allergy injections. The Fees are as follows:
 - a. Monthly injections- \$25.00/semester
 - b. Biweekly injections-\$50.00/semester
 - c. Weekly injections-\$100.00/semester
 - d. Twice Weekly Injections-\$200.00/semester

Consent for the Administration of Allergy Injections and Fees

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STUDENT NAME

STUDENT BANNER ID#

CAMPUS ADDRESS

DATE OF BIRTH

CITY

ENTRANCE DATE

HOME TELEPHONE #

CELL PHONE #

Authorization of treatment statement

I hereby certify that I have read the Rowan University Student Health Center Policy regarding the "Administration of Allergy Injections" and I agree to comply with these policies in the order to receive allergy injections at the Student Health Center. I hereby authorize the Rowan University Student Health Center staff to provide allergy injections. I understand the risks and possible complications, including anaphylaxis and death associated with these injections. I release the State of New Jersey, Rowan University, medical and nursing personnel, the employees, agents or assigns from any liability or claims or actions whatsoever for injuries or reactions arising from or related to any allergy injection. Also release the above from responsibility for replacement of serum that is lost or damaged. **I understand that I must wait 30 minutes following my allergy injection and be discharged by the RN after the site has been checked.**

I understand my one- time fee per semester of \$_____ for allergy injections is nonrefundable.

IMPORTANT NOTICE: A NEW FORM MUST BE SIGNED YEARLY PRIOR TO ADMINISTERING ALLERGY INJECTIONS. Complete information regarding the nature of allergies and specific direction concerning the injections, signed by the allergist, must be received and reviewed by the Student Health Center prior to the first allergy injection.

STUDENT SIGNATURE

DATE

PARENT OR GUARDIAN SIGNATURE (FOR STUDENTS UNDER 18 YEARS OF AGE)

DATE



Student Health Center
Allergy Injection Schedule

Patient Name: _____ DOB: _____

Frequency of Injections to be Administered: _____

Injection #___ Concentration: _____

Injection #___ Concentration: _____

Injection #___ Concentration: _____

		Injection #___		Injection #___		Injection #___		
Dose	Date	Amount to be Given/Arm	Reaction	Amount to be Given/Arm	Reaction	Amount to be Given/Arm	Reaction	RN Initials
1.								
2.								
3.								
4.								
5.								
6.								
7.								
8.								
9.								
10.								
11.								
12.								
13.								
14.								
15.								

Special Instructions:

Physician's Signature (Mandatory)

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