Goddard Health Center
620 Elm Ave. Norman, OK 73019
Phone (405) 325-4611 **Fax** (405) 325-7542

GODDARD HEALTH CENTER ALLERGY INJECTION CLINIC
GUIDELINES AND PATIENT AGREEMENT

Please read each line and initial to agree with the terms.

____ I agree to provide all serum for my allergy injections.

____ I am aware that Goddard Health Center does not initiate allergy immunotherapy and documentation is required from my primary allergist of prior injections.

____ I agree to have an Epi-Pen with me at every appointment and I understand that if I do not, my allergy injection will not be given.

____ I agree to remain in the clinic in designated waiting area for 30 minutes following my injection. I also agree to allow one of the nurses to check the injection site(s) at the end of the 30 minutes. I understand that leaving prior to the 30 minutes will be viewed as leaving "Against Medical Advice" and could affect my insurance payments and my ability to continue to receive allergy injections at Goddard Health Center .

____I am aware that I will not be able to receive my allergy injection if I am currently experiencing asthma symptoms or if I am taking a beta-blocker.

____I am aware that I will be required to return to my primary allergist for evaluation if I miss 3 consecutive doses or if more than 8 weeks has passed since my last injection.

____I am aware that it is my responsibility to cancel an appointment one hour prior to that appointment. I am also aware that if I fail to do so I will accrue a $20 "NO SHOW" fee.

____I am aware that if I have 3 "NO SHOW" appointments in one semester that I will no longer be able to receive allergy injections at Goddard Health Center. I am also aware that I am responsible for canceling any previously scheduled appointments.

____I agree to notify Goddard Health Center of any changes in my demographic information, e.g. address, phone number, etc.

____I am aware that it is my responsibility to checkout my serum if I am leaving campus for an extended period of time or I am returning to my allergist. I am aware that Goddard Health Center will not ship my serum.

____I am aware that any expired serum will be discarded through the Goddard Health Center Pharmacy and will not be administered.

____I am aware that in the case of any anaphylactic or systemic reaction, I will be required to return to my allergist for evaluation prior to receiving any future allergy injections at Goddard Health Center. Documentation of safe resumption of allergy immunotherapy will be required.

____I am aware that I will not be allowed to schedule "SAME-DAY" allergy injections.

____I understand and agree the Goddard Health Center and/or its employees will not be financially responsible for any loss or damage to medication furnished by me or my physician while in the custody of Goddard Health Center. I also understand that Goddard Health Center will dispose of medication left beyond its expiration date and has my permission to dispose of my medication if I have not reported to Goddard Health Center for treatment for two consecutive months.

Print name	D.O.B.	OU ID #

Signature of patient	Date