



Patient Agreement for Allergy Immunotherapy Administration

Patient Name: _____ **Date of Birth:** _____

NOTE:

- University Health Services (UHS) will not administer injections if you have had 2 or more anaphylactic reactions.
- We receive a high volume of allergy extract at the beginning of the semester. To expedite the scheduling of your appointment, please drop off/ship your serum and required paperwork as soon as you arrive on campus.
- In addition to completing this form, you must have your referring allergist complete the Referring Allergist Agreement form.

INSTRUCTIONS: Patients, requesting allergy immunotherapy at Penn State University Health Services (UHS), are required to complete this form yearly. Read carefully prior to signing the Patient Agreement.

Deadline: This form must be completed and received in the Allergy Clinic prior to scheduling the first appointment. This agreement will expire at the end of the 2025-2026 academic year and new agreement forms must be provided to continue immunotherapy.

I understand and agree if I am to receive allergy immunotherapy injections at the Allergy Clinic at Penn State UHS, the following must be completed:

Establish Care: _____ (initial)

I understand that if I have not been seen by a UHS clinician, I must first schedule an appointment with a UHS clinician before receiving allergy injections at UHS. This only needs to occur once. This can be done by making an appointment online at <https://studentaffairs.psu.edu/health/myuhs> or by calling 814-865-4UHS (4847), Option #2. I understand that UHS does not initiate treatment. The first injection must be received at my allergist's office and then UHS will administer subsequent injections. I will check in at the kiosk each time I visit the allergy clinic. I understand that I will receive a secure message when all required paperwork and allergy extract are received and checked in. I cannot schedule an allergy injection appointment until I receive this message.

Injection Schedule: _____ (initial)

I agree to abide by the injection schedule prescribed by my referring allergist. I understand that the risk for adverse reactions increases if immunotherapy injections are frequently missed. If I do not receive an injection for 60 days or more, I will need to return to my allergist to receive the next injection. UHS has the right to discontinue injections, after consultation with my allergist, if the prescribed schedule is not followed.

Checking out serum: _____ (initial)

I will give the nurses advanced notice of at least one business day when I need to check the serum out. If it is a last-minute request, I understand that I may need to come back another day to pick it up or wait until the nurse can complete the check-out process. I can choose to pick it up any time UHS is open except between the hours of 11:40 a.m.–12:40 p.m.



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Checking in Serum: _____ (initial)

I can drop serum off at the front desk at UHS anytime during business hours. During high volume times, such as the beginning of the semester, there may be delay of up to 2 weeks to get all serum processed into the clinic. I will receive a secure message from the allergy clinic when the serum has been processed, and I can then make an appointment. I cannot schedule an appointment until I receive this message.

Allergy Clinic Administrative and Safety Protocols: _____ (initial)

- If my allergist orders that I carry my EpiPen and/or take an antihistamine on injection days, I must follow that order. If I do not carry my EpiPen to present to the nurse, I will have to reschedule my appointment.
- If I feel sick, I will reschedule until I am feeling better. The allergy nurse has the right to reschedule my appointment if it is deemed I am not well enough to receive my injection due to illness.
- If I am on an antibiotic, I must be on it for 3 days and exhibit no symptoms. If it is less than 3 days or I still have symptoms, I need to reschedule my appointment.
- If I begin taking Prednisone or any steroid, I must complete the prescription and wait 24-48 hours before receiving an injection.
- If I receive a vaccination, I may need to wait 24 hours before receiving my allergy injection.
- I agree not to exercise for one hour before and one hour after receiving my allergy injection.
- I agree to alert the nurse about any health or medication changes or late reactions before my allergy injection.

Shipping of Allergy Serum: _____ (initial)

Penn State UHS will overnight ship my serum vials to my allergist upon my request. I understand there is a charge of \$50.00 associated with this service, that will be charged to my Bursar account. I will call my allergist when new allergy serum is needed. UHS will notify me by secure message when it has arrived at the UHS Allergy Clinic.

Serum can be shipped to:

University Health Services
Attn: Allergy Clinic
542 Eisenhower Road
University Park, PA 16802

UHS does not accept serum on Saturdays, Sundays, holidays or when UHS is closed.



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Risks and Side Effects: _____ (initial)

I understand that allergy injections are associated with some widely recognized risks. Possible reactions include local reactions at the injection site and generalized (anaphylactic) reactions which occur rarely but are more concerning because of the potential danger to progress to low blood pressure and death if not treated.

All generalized (anaphylactic) reactions require immediate evaluation and medical intervention at UHS. I will be transported to either Mount Nittany Medical Center or Penn Highlands, State College emergency department for observation via ambulance.

I understand that if I experience a generalized (anaphylactic) reaction, I must be evaluated by my allergist and receive the next allergy injection at their office before I can receive additional allergy injections at UHS. Generalized (anaphylactic) reactions may be of one or more of the following:

- Hives/urticarial reactions
- Swelling/angioedema reactions
- Anaphylactic shock-including acute asthma, low blood pressure, unconsciousness, and potentially death.

I understand that UHS will not administer allergy injections if I have had 2 or more anaphylactic reactions.

I will carry my EpiPen/(epinephrine), take an antihistamine on injection days, and/or perform peak flows if required by my allergist. I may not receive allergy injections if I do not follow my allergist’s instructions.

Observation Period: _____ (initial)

Generalized (anaphylactic) reactions are unpredictable and may occur with the first injection or after a long series of injections with no previous warning. Therefore, I agree to remain in the Penn State UHS 3rd Floor waiting room for a 30-minute observation period after each immunotherapy injection. I understand that if I leave before the 30-minute observation period, I will no longer be permitted to receive my allergy immunotherapy at Penn State UHS. I understand there are no exceptions to this policy. I will notify the nurse immediately if I experience itching, runny nose, shortness of breath, nasal congestion, wheezing, flushing, facial swelling, sneezing, hives, cough, anxiety or “pins and needles” sensation of the skin.



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New Information: _____ (initial)

I agree to notify the Penn State UHS medical staff if I start any new prescription medications, particularly medication for high blood pressure, migraine headaches, or glaucoma. “Beta blocker” medications, often prescribed for heart disease or high blood pressure, are usually not allowed while on immunotherapy. I understand that Penn State UHS will not administer allergy injections to patients taking these medications. If I become pregnant while on immunotherapy, I will notify medical staff at Penn State UHS as well as my allergist. I understand Penn State UHS does not administer allergy Injections during pregnancy.

Penn State UHS Roles: _____ (initial)

Penn State UHS will store my extracts between 2°and 8°Celsius (35.6° and 46.4° Fahrenheit). I will not hold Penn State UHS responsible for the integrity of the extract in the event of a power failure, storage equipment failure, or catastrophic event that may corrupt the integrity of the extract. I further authorize the clinicians and nurses at Penn State UHS to review my medical care, recommend appropriate medical intervention, and discuss my medical care with my ordering provider and me.

Limits of Responsibility: _____ (initial)

Penn State UHS cannot guarantee the integrity of any extract prior to receiving it. I also understand that:

- Penn State UHS is not my primary care provider in respect to this therapy.
- My medical management related to this therapy, therapeutic monitoring of the therapy, and any necessary follow-up care are the responsibilities of my referring allergist.
- If I have questions regarding the therapy or my medical condition related to the therapy, they should be directed to my referring allergist.

Patient Agreement: I request that Penn State University Health Services (UHS) administer allergy immunotherapy as prescribed by my referring allergist. I understand that Penn State UHS is administering this therapy as a service for me because my referring allergist is not on staff at Penn State UHS.

Patient or Authorized Guardian Signature: _____ **Date:** _____

Patient Name (printed): _____ **Date of Birth:** _____

Patient PSU ID Number: _____

After completing, signing, and dating this form, please bring form to your appointment at Penn State UHS or fax form to: ATTN: Allergy Nurse 814-863-3511.