MERCY UNIVERSITY

Physician Allergy Injection Order and Approval Form

Patient Information:		
Name:	DOB:	Date:
Allergist Information:		
Name:	Phone #:	
Fax#:		
Address:		

Yes _____ No _____	I give my permission for the Mercy University Student Health Office to administer allergy injections per my orders to the patient named above.
Yes _____ No _____	I certify that the patient has and will continue to receive the first allergy injections from a newly mixed allergen vial(s) in my office with no systemic reactions noted.
Yes _____ No _____	I understand this order must be signed/renewed annually or at the time of any changes in medical status.
	Signature _____ Date _____