

Michigan State University Olin Student Health Center Allergy/Immunization Clinic

463 East Circle Drive

East Lansing, MI 48824-1037

517-353-9763 (Phone) 517-432-9460 (Fax)

INJECTABLE MEDICATIONS GIVEN IN ALLERGY/IMMUNIZATION CLINIC

Patient Name: _____

Home Address: _____

Local Address: _____

Contact Numbers: _____

Birthdate: _____

I hereby authorize Dr. _____
(Private Physician)

to release the following information to Olin Student Health Center and authorize Olin Student Health Center to release information pertinent to allergy or injectable medication treatment to my physician.

Physician Name: _____

Address: _____

Patient Signature: _____ Date: _____

Authorization must be signed by the patient (or legal guardian if the patient is a minor).
PRIVATE PHYSICIAN: Complete form and return this copy in the attached envelope to Olin Health Center Allergy/Immunization Clinic.

All medications must have an expiration date. Serum will not be used beyond the expiration date.

Diagnosis: _____

(1) Brief history and physical pertinent to diagnosis requiring injection(s): _____

(2) Treatment Plan including any laboratory requirements for treatment: _____

(3) Further information important for those providing injection(s) (e.g. expected length of therapy, teaching for self-injection etc.):

Physician Signature: _____ Date: _____ Print Name: _____

Contact Number: _____ Fax Number: _____

Olin Health Center Staff Review/Sign

Physician Signature: _____ Date: _____

Nurse Signature: _____ Date: _____