MERCY COLLEGE

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 College 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 _____