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 Clinical Health Services and authorize Olin Clinical Health Services 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 the 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: _____

(l) 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: _____