CNU HEALTH AND WELLNESS CLINIC
1 AVENUE OF THE ARTS
NEWPORT NEWS VA 23601
757-594-7661

# VACCINATION/MEDICATION AUTHORIZATION & CLINIC STORAGE FORM

This form will detail the necessary requirements for CNU Health and Wellness Clinic to hold & administer a student's Vaccination/Medication. This authorization form must be signed by the student. If the student is under the age of 18 he/she must have a parent/legal guardian sign the form.

1. Medications/Vaccines can be dropped off at the clinic Monday – Friday from 830am to 5pm.

2. All Medications/Vaccines must be picked up from the clinic in the event of a campus closure, i.e., Fall Break, Winter Break, Spring Break, etc. During shut down times, students will need to make alternate arrangements to have the Medication/Vaccine administered by a Medical Professional.

3. All Medications/Vaccines must be accompanied with a Prescription from the authorizing physician. This prescription must include instructions on dosage amounts, frequency, length of administration for the Medication/Vaccine and Physician contact information to include Address & Phone.

4. For individuals receiving Allergy injections, it is required you wait a full 30 minutes after your vaccine before leaving the Clinic.

5. For individuals receiving Allergy injections there is a $15.00 administration fee due at the time of injection. This is not a billable charge.

I have read the authorization for medication/vaccine administration and I hereby request and authorize CNU Health and Wellness Clinic/Riverside Health System personnel to administer this medication/vaccine as directed. I agree to release, indemnify, and hold harmless CNU Health and Wellness Clinic/Riverside Health System and any of their officers, staff members, or agents from lawsuit, claim, demand, or action against them for administering medication to this student. **I understand that *permission is granted* for exchange of written communication between the Health and Wellness Clinic and the prescribing physician.**

_____ _____
Student Signature Date

_____ _____
If Student is under the age of 18 Date
Parent/Legal Guardian Signature REQUIRED

ALLERGY INJECTION ADMINISTRATION FORM
**TO BE FILLED OUT BY THE PRESCRIBING PHYSICIAN**

CNU Health and Wellness clinic is pleased to administer your patient's allergy immunotherapy. Our clinic administers allergy injections prescribed by many different allergists. The following form provides standardization to prevent errors.

Please complete this form by filling in the appropriate blanks and sign at the bottom. This form will be used by CNU Health and Wellness clinic when we administer allergy injections to your patient. By signing this form, you agree with the guidelines and instructions on this sheet.

PLEASE PRINT CLEARLY!

Patients Name: _____ DOB: _____

Physician: _____

Address: _____

Phone: _____ FAX: _____

## ALLERGY THERAPY INJECTION ORDERS

| Vial# | Contents | Strength | Frequency | Expiration Date | Date of last Injection | Reaction |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |

Dosage Schedule:

Build Up: Administer Shots q_____days. Once Maintenance dose of

_____ is reached, administer shots; q_____ days.

q_____ weeks

q_____ month

start with _____cc, and increase by _____cc every _____ days.

Other Instructions:_____

_____

_____

Physician Signature_____ Date_____