



STAMPS HEALTH SERVICES

www.health.gatech.edu /404-385-4995

Allergy Prescreening Questionnaire

Name: _____ Today's Date: _____

GT ID #: _____ GT E-mail: _____

Birth Date: _____ Phone Number: _____

1. For which reasons are you receiving allergy shots?
Seasonal Allergies _____ Skin Allergies _____ Insect Allergies _____ Asthma _____
2. Do you have any allergies to medications? If so, please list.

3. What medications does your allergist prescribe for your allergies?

4. What medications do other doctors prescribe for you and why?

5. What over-the-counter medications do you take routinely?

6. Do you have any lung or heart problems? If so, please explain.

7. Have you had any breathing problems over the last 7 days? _____
8. Does your allergist require you to use a peak flow meter before receiving allergy injections? _____
9. How long have you been receiving allergy shots? _____
10. When was your last allergy shot? _____ Was that shot given on time? _____
11. Was there any swelling at the injection site after your last shot? _____
12. Have you ever had a serious reaction after your allergy injection, such as shortness of breath, wheezing, or swelling? Have you ever required hospitalization or intubation following allergy injections? _____
13. If yes to any of the above questions, please explain. _____

Please provide us with the following information about your allergist.

Name of Allergy Office/Location: _____

Name of Allergist: _____

Hours of Operation: _____

Phone Number: _____ Fax Number: _____



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Allergy Appointment Information

Allergy injections will never be given without a physician's presence in the facility. Please schedule appointments during the following times:

Monday 8:10 am – 11:20 am & 1:00 pm – 3:00 pm

Tuesday 8:10 am – 11:20 am & 1:00 pm – 3:00 pm

Wednesday 8:10 am – 11:20 am & 1:00 pm – 3:00 pm

Thursday 9:10 am – 11:20 am & 1:00 pm – 3:00 pm

Friday 8:10 am – 11:20 am & 1:00 pm – 3:00 pm

****Please note that our department is closed for lunch daily from 12:00 pm – 1:00 pm.***

1. Please make an appointment each time you need an allergy injection. Appointments can be made at the front desk, by phone (404-385-4995) or online at www.health.gatech.edu
2. The Student Health Fee included in your tuition allows you to receive injections at Stamps Health Services. There is an additional allergy semester fee of \$90 for Fall and Spring and \$60 for Summer. This allows you to receive injections as often as you need them for the duration of the semester.
3. Please sign the HIPAA Release of Information and Allergy Consent Form.
4. We will store your allergy vials in our refrigerator while you are receiving injections from us. However, it is your responsibility to transport new allergy vials to and from our facility according to the policies of your own allergist.
5. Check in using the self-check-in computers in the lobby and proceed down the side hallway to the Travel, Immunization, and Allergy Clinic. Sign in at the window and have a seat in the waiting room until your name is called.
6. Please remember that it is your responsibility to come to your appointments as frequently as your allergist recommends. If you wait too long between injections, your appointment may be delayed, or you may need to return on a different day. Please understand that we will not act independently of your allergist's office, and we will not proceed with your injections until we have received information about your dose adjustments if you are off schedule.



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Allergy Injection Consent

1. Avoid exercise 2 hours before and 2 hours after injections, such as jogging, vigorous walking, gym workouts, etc.
2. **You MUST bring your epinephrine injector with you each time you come for an allergy injection.**
3. If your allergist requires you to take an antihistamine before your injection and you have not done so, ***you will need to reschedule.***
4. Certain prescription medications for eye problems, headaches and blood pressure problems contain beta-blockers. Beta-blockers can increase the sensitivity to allergens and also potentiate anaphylaxis. It is **IMPERATIVE** that you inform the nurse **BEFORE** receiving *any* allergy injections if you are taking *any* beta-blockers.
5. Avoid rubbing or scratching injection sites.
6. You MUST have injection sites checked by a nurse **30 minutes** after injection. There are no exceptions to this policy. You must wait inside the Stamps Health Services building during your wait time.
7. While waiting to have your injection sites checked, notify the nurse if you experience any of the following symptoms: ***runny nose *itching *shortness of breath *nasal congestion *wheezing *flushing *facial swelling *pins-and-needles sensation of the skin *sneezing *hives *coughing *anxiety**
8. Although you may not experience any local reaction (redness, itching, or swelling at the injection site) within the 30 minutes after the injection, it is possible to react later in the day. If a local reaction occurs:
 - Take an antihistamine (Claritin, Zyrtec, Allegra, Benadryl, etc.)
 - Record the time and size of the reaction and how long it lasts. Report this to the nurse **BEFORE** receiving the next injections. If the symptoms continue or worsen, return to Stamps Health Services or go to the nearest emergency department (Emory Midtown, 550 Peachtree St. NE, Atlanta, GA) or call 911.

I, _____ (patient's name) am presently under the medical supervision of Dr. _____ of _____. I relieve the Board of Regents of the University System of Georgia, Georgia Institute of Technology and all of their respective employees of all responsibility, direct and indirect, of all physical harm including, but not limited to, reaction(s), risk, hazard, and shock, incurred in the administration of allergy injections that have been specifically prepared and furnished to Stamps Health Services by the above named physician, and to be given at prescribed intervals by the nursing staff of Stamps Health Services. I agree to fully abide by the above listed guidelines and understand that deviation from the standards will result in termination of injections at Stamps Health Services.

Signature _____ Date: _____