

**ROCHESTER INSTITUTE OF TECHNOLOGY  
STUDENT HEALTH CENTER**

**Allergist Consent Form**

Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_\_

I have read the R.I.T. policy for the administration of allergy injections in the Student Health Center. I agree with the guidelines.

According to the Student Health Center policy, a nurse practitioner or physician must be present in the Student Health Center when an allergy injection is given. **If your practice policy requires that a MD be on-site, please check box below.**

MD must be present

I have read the R.I.T. policy for the administration of allergy injections in the Student Health Center. I agree with the guidelines.

Allergist Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Allergist Name Printed: \_\_\_\_\_

Please fax completed form to 585-475-7788. Thank you

Rochester Institute of Technology  
Student Health Center  
117 Lomb Memorial Drive  
Rochester, New York 14623  
585-475-2255 (v) 585-475-5515 (tty)  
Fax: 585-475-7788